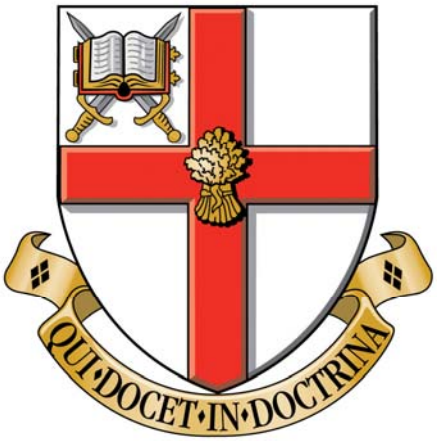


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# The National Healthy Schools Programme: a vehicle for school improvement? Case studies from Cheshire

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# Summary


**Background and aims**

The school has consistently been identified as a key setting in which to improve both health and educational outcomes for children and young people. The aims of the Government's National Healthy Schools Programme imply that schools, by achieving healthy school status, can contribute to outcomes relating to health, educational attainment and social inclusion. However, there is little research on the relationship between healthy school status, school improvement and educational attainment either in terms of outcomes, or in terms of the processes through which outcomes might be reached. This research set out to explore the relationship between healthy school status and school improvement. The aims of the research project were to:

- understand the process through which the National Healthy School Standard initiated change in identified schools;
- explore the consequences of change – intended and unintended – from a variety of stakeholders' perspectives;
- explore the relationship between identified changes and outcomes;
- reconsider the role of the National Healthy School Standard in bringing about school improvement.

**Methodology**

A case study approach to the research was adopted in which three primary schools at different stages of involvement with the healthy schools programme, were recruited to the study. Case studies typically use multiple methods and the following methods of data collection were used to operationalise the aims:

- semi-structured interviews with school teachers with a specific role in the implementation of the initiative in their school;
- focus groups with school children;
- non-participant observation of activities that had been introduced as a result of involvement with the healthy schools programme;
- documentary analysis of sources that had been produced as a result of the accreditation process, for example, the school audit, agendas and minutes from school council meetings;
- analysis of secondary data sources such as the latest Ofsted Inspection Report.

## Findings

### 1 Understanding the role of the National Healthy School Standard in initiating change

It was evident that the National Healthy School Standard was seen as a catalyst for change within schools in three ways:

- the framework and process stimulated and enabled schools to address existing problems, such as bullying and playground behaviour, in a systematic way;
- it provided impetus to reviewing the use of existing resources, such as the way the playground was organised and used;
- it provided a rationale for developing new ways of working with children by providing ideas for enabling their participation through the creation of a school council.

### 2 Characteristics of the National Healthy School Standard that facilitated change

The features of the National Healthy School Standard that were viewed as facilitating schools' involvement with the initiative were:

- the framework gave emphasis to the importance of a 'whole school approach' to the work, which was consistent with the way in which the three case study schools wanted to work;
- the whole school approach meant that it was possible for schools to develop consistent links between the curriculum and the wider school environment, such as in relation to developing work around citizenship;
- because the framework was based on a broad concept of health in which health and educational outcomes were seen as inter-related, this allowed the joining up of a variety of initiatives into a coherent and consistent approach to the development of policy and practice;
- the emphasis on 'giving pupils a voice' was seen as highly desirable in the case study schools;
- the framework was seen as providing a helpful structure to the accreditation process without being overly prescriptive, such that schools could identify their own priorities and targets;
- the case study schools thought that the values of the healthy schools programme were consistent with the schools' values such that it was easy to engage with the initiative.

### 3 Understanding the impact of change on school improvement

In terms of school improvement the case study schools viewed the impact of changes they had introduced as part of the healthy schools process as operating at two inter-related levels: namely the school and the individual child. This was explained in the following ways:

- consulting with, and involving children was seen as the foundation from which better standards of behaviour and an improved school ethos would develop;
- developing and proactively implementing strong anti-bullying and behaviour management policies, together with the development of participative structures for enabling children's involvement in the life of the school, led to improvements in the physical and social environment of the school, which helped create a setting that engaged children and was conducive to learning;
- enabling the participation of children led to changes in the quality of relationships between teachers and children;
- collectively, these changes in the physical and social environment of the schools were seen as contributing to the development of children who were predisposed to learn;
- school improvement was seen primarily in terms of creating the conditions within which children can flourish rather than in hard quantitative performance measures.

## Discussion

Whilst the relatively small scale nature of this research limits its generalisability, the main value of case study research is in terms of generating rich data from which explanations can be developed. In terms of how the National Healthy School Standard might act as a vehicle for school improvement a number of points can be made:

- policies and practice are inter-related and can make a difference to the life of the school because they are the mechanisms through which values and priorities are transmitted. This may go some way towards explaining the role of the school in effecting positive health and educational outcomes, particularly for those children and young people who are most at risk of exclusion;
- given the fact that the experience of bullying is a major factor in undermining individual health and wellbeing as well as the ethos of the school, strategies

to manage its occurrence, as revealed in the three case study schools, are likely to lead to beneficial outcomes;

- it is not only academic achievement that matters in terms of understanding children and young people's trajectories into adulthood. Rather, the extent to which children have been engaged with school appears to have important ramifications for their life chances.

The findings from this study generally support the notion that the NHSS can be a vehicle for school improvement. However, there remain a number of challenges:

- it will be important to find ways of engaging those schools who are perhaps reluctant to consider the healthy schools programme as a school improvement initiative as they are likely to be the ones that have most to gain from it;
- finding more sensitive and specific ways of measuring the impact of the NHSS would be valuable. However, the impact on outcomes such as attendance and lifestyle might be seen as appropriate short term indicators.

Whilst it is likely that pressure from policy makers nationally and locally will be for 'hard evidence' of outcomes (usually interpreted as quantitative measures of performance) it may be of value to ensure that efforts are made to capture change at the level of the school in terms of policies and practice. Health and educational outcomes are often reached indirectly rather than directly, and revealing the role of the individual school setting – in terms of culture, ethos and structures such as a school council – in mediating outcomes is likely to be important in understanding the processes through which schools improve. Furthermore, this suggests that schools have an important role in helping children and young people overcome some of the negative dimensions of living in disadvantaged circumstances.

# Chapter 1
# Introduction

## 1.1 The National Healthy Schools Programme and school improvement

The school has consistently been identified as a key setting in which to improve both health and educational outcomes for children and young people (Rivers et al., 2000). The Government's National Healthy Schools Programme (NHSP), launched in 1999 with the aim of promoting healthy schools work within a national framework of quality standards – the National Healthy School Standard (NHSS) – was explicitly concerned with addressing health inequalities and social inclusion, developing healthy lifestyles, and improving educational standards through school improvement (Health Development Agency [HDA], 2002). Since 1999, the Government has increasingly focused its attention on children and young people, reflected in the *Every Child Matters* Green Paper (Department for Education and Skills [DfES], 2003) and the *Children Act* (2004). This policy framework sets out five national outcomes for children and young people and articulates a vision of the contribution of schools towards the achievement of these outcomes. To reflect this shift in policy direction, new guidance on the NHSP was published by the Department of Health (DoH) in 2005. Whilst the new guidance continues to emphasise the original aims of the NHSS, it places more emphasis than hitherto on the development of healthy behaviours, reflecting the growing concern with children and young people's health and wellbeing. The framework of quality standards has been replaced by four core themes, each underpinned by a set of specific criteria that define the areas of work on which schools are required to focus in order to achieve healthy school status. Schools are required to evidence their achievements in relation to all of the four core themes.

The strategic aims of the NHSP imply that schools, by achieving healthy school status, can contribute to outcomes relating to health, educational attainment and social inclusion. However, there is little research on the relationship between healthy school status, school improvement and educational attainment either in terms of outcomes, or in terms of the processes through which outcomes might be reached. There is however, some evidence to suggest that schools that have achieved healthy school status through the national accreditation process have made improvements in the following areas: behaviour of pupils; standards of work in the classroom; quality

of the Personal Social and Health Education (PSHE) curriculum; and, management and support of pupils (HDA, 2002).

A brief review of the school improvement and school effectiveness literature indicates that there is considerable convergence between the philosophy of the NHSP and the emerging consensus on how to improve schools. For example, both the NHSP and guidance on school improvement emphasise the importance of a 'whole school approach' to the management of change and underscore the importance of school culture and ethos as part of the change process. What this suggests is that schools that have achieved healthy school status may, directly or indirectly, be creating the conditions within which improvements in pupil outcomes are more likely. Thus, it was the purpose of this research project to explore, through a number of case studies, the extent to which the NHSP was a vehicle for a school's improvement.

It should be noted at this juncture that this research took place during a period of considerable policy activity in relation to children and young people and the ways in which services, including schools, were required to respond to their needs and encourage their development. Terminology in respect of the healthy schools work changed during the time of the research from an emphasis on the NHSS to a focus on attainment of healthy school status through achievement against key criteria. For clarity, this report uses the terminology of the NHSS to refer to healthy schools work as this was the primary organising framework for schools during the period of field work.

### 1.2 Aims of the research

The aims of the research project were to:

- understand the process by which the NHSS initiated change in identified schools;
- explore the consequences of change – intended and unintended – from a variety of stakeholders' perspectives;
- explore the relationship between identified changes and outcomes;
- reconsider the role of the NHSS in bringing about school improvement.

### 1.3 Study design

Exploring relationships between cause (for example, the NHSS intervention) and effect (for example, school improvement) is difficult in uncontrolled and naturalistic

environments in which there are many confounding factors at play. This makes the attribution of any *one* outcome to a specific intervention difficult. Furthermore, an important aspect of this study was to explore the processes through which possible outcomes might have been realised. These considerations necessitated the use of a study design that conceptualised the school setting as a complex, social system and the NHSS as a multi-dimensional policy intervention. Thus, a case study approach was used, with three primary schools being studied in depth.

The decision to study primary schools only was taken for three reasons. Firstly, from a pragmatic point of view, negotiating access to primary schools and gaining informed consent to participate in the research was judged to be easier than for secondary schools. Secondly, there was some evidence to suggest that primary schools had been more successful in initiating changes that related to school improvement as a result of the NHSS, which suggested that primary schools might be worthy of investigation and reveal some important findings. Finally, given the size and complexity of secondary schools, researching processes and consequences was judged to be too problematic within the timescales and resources.

### 1.4 Structure of the report

After this brief introduction, Chapter 2 explores the policy background driving the focus on children and young people's health and educational attainment and the role of schools in bringing about positive outcomes for pupils. It looks in some depth at the development of the NHSS and explores its convergence with the emerging consensus on school improvement. Chapter 3 describes the study design for the research as well as providing background information about the case study schools that were the focus for the work. The findings from the fieldwork are presented in Chapters 4, 5 and 6. All the material generated from the fieldwork was combined into one dataset in order to explore key themes that related to the study's aims. Thus, Chapter 4 explores the role of the NHSS in initiating change within schools. Chapter 5 explores the consequences of change in respect of the school environment and outcomes for children. Chapter 6 presents a reconsideration of the role of the NHSS in school improvement. The report concludes with Chapter 7, which discusses the implications of the findings and theorises about the role of the NHSS in school improvement.

# Chapter 2
# Literature Review

## 2.1 Introduction

Chapter 2 locates the study within the broad policy context that relates to children and young people's health and educational attainment and the development of schools as healthy settings. Specifically, it describes and discusses the NHSS and its subsequent development in respect of the NHSP, the national framework within which healthy schools work is organised and delivered, and the putative relationship with school improvement. A central theme of the NHSS and the NHSP is to consult with pupils and give them a voice within the school setting. This chapter therefore also explores the ways in which children are enabled to participate in the life of the school and some of the consequences of this more democratic approach to the operation of schools.

## 2.2 The development of schools as healthy settings: the policy context

The notion of schools as healthy settings has a long history dating back to the beginning of the 20th Century (Beattie, 1996). However, in the past decade, the evidence linking health and educational attainment has accumulated, providing a strong rationale for giving prominence within health and education policy to the role of the school in developing the health and wellbeing of children and young people. Thus, between 1997 and 1999 the UK Government explicitly identified the school as an important setting for improving the health of children and young people and, inter alia, enhancing their educational achievement in two White Papers: *Excellence in Schools* (Department for Education and Employment, [DfEE], 1997) and *Saving Lives: Our Healthier Nation* (DoH, 1999). In 1999, the DfEE and the DoH launched the National Healthy School Standard (NHSS), a national framework for local healthy schools programmes. The framework defined the content, breadth and approaches of local healthy schools programmes in terms of a series of 'quality standards', designed to drive up the quality of healthy schools work (DfEE, 1999). In retrospect, these developments can be seen as marking the beginning of a resurgence of interest by the Government in children and young people's aspirations, which has been followed by a plethora of child-focused policy initiatives. Thus, through the publication of the Green Paper *Every Child Matters* (DfES, 2003), the *Children Bill* (2004), the *National Service Framework for Children, Young People and Maternity Services* (DoH, 2004b) and the Public Health White Paper *Choosing Health* (DoH,

2004a), the Government has identified a number of cross-cutting strategic priorities that relate to the health, wellbeing and educational attainment of children and young people, as well as their active engagement in school and community life. There is, therefore a clear expectation that schools are seen as the settings in which these policy commitments are translated into action (HDA, 2004a) by, for example, the development of schools through the NHSP and the achievement of healthy school status.

### 2.2.1 The relationship between health and attainment

Evidence suggests that good health influences attainment and vice versa (Healy, 2004; World Health Organisation [WHO], 1996). As indicated above, there is a growing body of research that has explored the relationship between health, in its widest sense, and educational attainment. For example, the *Independent Inquiry into Inequalities in Health* (Acheson, 1998) concluded that educational attainment is a major factor in generating health inequalities. The pathways through which health is linked to attainment are likely to be complex but at a general level it is likely that there is convergence between the factors that determine educational attainment and improved health outcomes (St Leger & Nutbeam, 2000). In terms of what these factors are, some research studies have focused on specific aspects of lifestyle. For example, research that has explored the relationship between physical activity and attainment has shown that engaging in physical activity can lead to improved motivation and academic achievement (Symons, Cincelli, James & Goff, 1997; WHO, 1996). The role of poor diet in a child's cognitive development has also been explored (Powney, Malcolm & Lowden, 2000). More recently, the psychosocial aspects of children's health and attainment have been researched (Healy, 2002; Salmon, James, & Smith, 1998; Weare & Gray, 2003). This suggests that, in a fairly straightforward way, poor health (through genetic, lifestyle, nutritional factors, and so on) may be linked to poorer concentration and attendance, both of which can hinder a child's capacity to learn and achieve (Healy, 2004).

However, evidence suggests that more complex pathways can be traced that link health and educational achievement, and which, furthermore, influence the developmental trajectories of children and young people (Acheson, 1998). Thus, because of the way in which these two outcomes are related, small differences in health and achievement in early life are likely to generate an ever widening gulf between those who are successful and those who are less so. Furthermore, whilst poor health and under-achievement are linked to poverty, Healy (2004) has argued

that good education can help children and young people overcome these economic and social disadvantages in a way which is likely to track into adulthood. Powney et al. (2000), in their review of the research literature, found that children living in poverty were more likely to have poor physical health, spend less time in school and have poorer learning experiences.

This research suggests that it is important to consider what might be the precise role of the school in effecting positive health and educational outcomes for children. Powney et al. (2000) conclude that children's educational attainment is influenced by a variety of factors, some of which may be associated with the characteristics of the school. For example, in terms of policy development and implementation there is some evidence to suggest that schools that have positive policies for behaviour and anti-bullying as well as strong academic and non-academic opportunities are more likely to support the development of resilience in children and young people (Healy, 2004; Weare & Gray, 2003). This would suggest that the development and systematic implementation of policies in these areas provides a vehicle for transmitting the specific values and priorities of the school and is therefore likely to contribute towards a positive learning culture and ethos within the school. The DfES (2001) reports that schools that promote children's mental health have been identified as sharing a number of features that essentially relate to school culture (for example, a high trust environment based on democratic principles). These findings are supported by the Office for Standards in Education (Ofsted, 1999), which found that good, supportive and harmonious relationships between pupils and staff were found to be important influences on children's psychosocial health.

Emotional health and wellbeing was one of the four core themes of the NHSS and continues to be so under the revised guidance (DoH, 2005), the others being Personal Social and Health Education (PSHE), healthy eating and physical activity. Children and young people who have positive predispositions towards themselves, others and school in general – that is, have positive social and emotional health – are likely to be those that are engaged with school and have high levels of attendance and motivation. Weare and Gray (2003), Goleman (1996) and Weisinger (1998) report that school settings that actively try to promote the social and emotional competence of children and young people (though the curriculum as well as wider school processes) generate benefits in terms of learning, achievement and good behaviour. Much of the research from the USA has tended to focus on specific interventions to address particular issues rather than a whole school approach. For

example, recent research on nurture groups (Cooper & Tiknaz, 2005) suggests that they can be successful in improving attendance and enhancing attainment. However, Healy's work suggests that culture and ethos, reflected in the policies of the school (for example in respect of bullying) and defined by the relationships between teachers and pupils, are likely to be a more important factor in supporting the emotional and social health of pupils (Healy, 2002; Healy, 2004).

A recent report by Hammond and Fernstein (2006, p. 1) on a study that explored the relationship between aspects of schooling that are markers for health and wellbeing in adulthood concluded that:

> …the differences in adult health and wellbeing between those who flourished at secondary school and those who did not are substantial and pervasive and go beyond the effect of qualifications attained, indicating the importance of engagement at school as well as academic attainment.

This suggests that the school setting has an important role to play in creating the conditions within which children and young people can thrive and enjoy school life, which in turn is likely to lead to better health and educational outcomes.

### 2.2.2 The National Healthy Schools Programme

The NHSS, and its successor the NHSP, is not a school improvement programme. The NHSS has been described as a "national guidance framework for local education and health partnerships" (HDA, 2002, p.3). In England, every primary care trust and local education authority has been accredited as a health and education partnership, the role of which is to support schools in achieving healthy school status. The *National Healthy School Standard Guidance* (1999) set out a national framework for local healthy schools programmes in terms of nine themes.[1] Fundamental to the NHSS has been the emphasis on a 'whole school approach' and giving pupils a voice. Thus, the Standards set out in the framework relate to the creation of a social and physical environment that is conducive to health, wellbeing and educational achievement, as well as the content and delivery of subjects such as PSHE through the formal curriculum (HDA, 2002).

Since its launch in 1999, healthy schools work within local health and education partnerships has undergone further development. During Phase 1 (1999-2002) the

[1] NHSS themes include: healthy eating, physical activity, drug , alcohol and tobacco education, emotional health and well being, sex and relationships education, safety, local school priorities. The NHSP refers to four core themes each with their associated criteria.

emphasis was on the accreditation of local health and education partnerships and the engagement of schools in the NHSS accreditation process, particularly those in areas of high socioeconomic deprivation. The strategic priorities for the NHSS in Phase 2 of its development can be seen in terms of identifying the impact of the initiative in terms of outcomes at the level of the individual as well as the school:

- to make an explicit contribution towards tackling health inequalities;
- to promote social inclusion;
- to encourage high standards in schools through school improvement activities. (HDA, 2002, p. 12).

In 2005, a fourth strategic priority was identified in order to address the increase in childhood obesity: to support children and young people in developing healthy behaviours. The recent guidance from the DoH (2005) reinforces this emphasis on healthy behaviours by articulating the following four core themes:

- personal, social and health education (including sex and relationship education and drug education);
- healthy eating;
- physical activity;
- emotional health and wellbeing (including bullying).

The emphasis on a whole school approach, consultation and participation of children and young people in the life of the school, and school improvement remain central to healthy schools work. This reflects the view that working towards healthy school status is a developmental, inclusive and holistic process.

The explicit linking of the strategic priorities identified above with healthy schools work reflects the Government's view that schools have an important role in improving health and educational attainment, at least in part, through children and young people's engagement in school and community life (HDA, 2004b). Furthermore, the linking of the NHSP directly with school improvement necessitates some consideration of the pathways through which health and educational outcomes might be improved. One mechanism is the active participation of children and young people in the life of the school, as suggested above. In policy terms, the participation of children and young people is currently of considerable importance and is a cornerstone of the healthy schools work.

At a local level, each accredited health and education partnership was required to draw up a framework that sets out guidelines for local implementation of the NHSS. In Cheshire, this guidance is encapsulated in the Cheshire Healthy Schools Handbook, developed in consultation with schools and young people, which sets out the process model (see Appendix 1) and specifies the standards to be achieved for the school to be accredited at Level 3. The guidance draws attention to the process of becoming an accredited healthy school and it is evident that this process is seen as one of enabling each school's development, as well as one that itself is developmental.

Some schools have been involved with the NHSP for four or more years and there is increasing pressure to demonstrate evidence of its impact.

### 2.2.3 Evidence of impact

Whilst there is evidence of a relationship between health and educational attainment, providing evidence for the impact of specific interventions is more difficult for a variety of reasons. It is relatively easy to find positive reports about the impact the NHSS has had from those involved with the initiative (Jackson, 2004). However, there has been an increasing emphasis on measuring its impact on children and young people's health and educational achievement. This section explores the research that has been carried out on the impact of the NHSS. It will also discuss the issue of evidencing impact and some of the problems of measuring individual outcomes in complex, multifaceted interventions delivered in schools.

An independent analysis by Ofsted of Section 10 of the Ofsted school inspection reports between September 2000 and July 2001 provides some of the earliest evidence of impact. Even at this relatively early stage in the implementation of the NHSS Ofsted found that Level 3 primary schools scored higher than the norm on a range of measures including behaviour, enthusiasm, personal development and PSHE provision (Ofsted, 2002). In addition, Level 3 schools were improving at a faster rate in four areas:

- behaviour;
- standards of work;
- quality of PSHE curriculum;
- management and support of pupils.

In 2002, the Scottish Council for Research in Education carried out a comparison of Level 3 schools and reported that the healthy schools programme had a positive effect on Key Stage 2 Science Standard Assessment Tests. However, research carried out by Blenkinsop et al. (2004), which analysed school level data from the previous four years, found that whilst the NHSS was popular with participating schools – largely because it had improved the status of their health-related work – there were few unambiguous quantitative differences between Level 3 schools and other schools. For example, analysis of the national pupil dataset yielded little evidence of an association between Level 3 schools and attainment in core subjects. Analysis of the Ofsted inspection database indicated that, after controlling for other factors, Level 3 primary schools were likely to score higher on all but one of the 11 scales investigated. An analysis of the Health Related Behaviour Questionnaire (Blenkinsop et al., 2004) in terms of the comparison between Level 3 schools and others was also inconclusive. Blenkinsop et al. (2004) discuss the ambiguousness of the results in terms of the fact that the time at which the research was carried out – 2001/2 – was relatively early in the roll out of the initiative. This meant that participating schools had a limited time within which to effect change at either the level of the school or individual pupil. Ofsted (2002) has also pointed out that many schools are involved in several initiatives making it difficult to tease out the impact of any one. From a research point of view measuring small incremental changes is difficult, however, they may, cumulatively, lead to relatively large impacts. This makes measuring the impact of the NHSS very difficult. However, Blenkinsop et al., (2004) concluded that the NHSS is beginning to have an influence, particularly in areas related to social inclusion. For example, the study found that the NHSS allowed the integration of other initiatives into a more coherent whole and pupils valued the improvements in ethos and social relations

Sinnott's study (2005) of 2,314 schools in 16 LEAs explored the impact of healthy school status and improvements in standards using Key Stage 2 performance. He looked at the total proportion of pupils achieving Level 4 or higher in English, maths and science over one and two years. The rates of improvement were higher for schools having achieved healthy school status compared to those which had not – the equivalent of a 0.5% increase in each of the three subjects. However, the accelerated rate of progress was not universal; for some local authorities, those not involved in the scheme were doing better. This perhaps is unsurprising given the local variation in healthy schools programmes (Blenkinsop et al., 2004).

Other authors have looked at impact in terms of the school environment. Falgate, Lawn and Britton (2003) have brought together a range of examples of how healthy schools contribute to raising children's achievement. In essence, these examples either reflect activities that address the ethos and culture of the school, for example through encouraging children and young people's participation, or situations in which a specific policy or activity has been introduced, such as a comprehensive, age-appropriate drug education programme. They argue that the three aspects of the NHSS that make it effective are leadership, management and managing change, school culture and environment and, giving pupils a voice. Cole (2004) quotes Marilyn Toft who highlights the role of the NHSS in helping the school establish a climate and environment conducive to learning. In this respect, the links between the NHSS and school improvement begin to emerge, as Schagan and Warwick (2004) have identified:

- a focus on processes not topics;
- attends to the quality of social relationships and physical environment;
- takes a whole school approach that addresses structure and culture;
- listens to, acts on and integrates pupils' voices into the everyday life of the school.

The literature cited above defines the whole school approach in terms of developing a whole school environment that supports learning and promotes the health and wellbeing of all through consulting with, and encouraging the participation of, all members of the school community. Schagen and Warwick (2004) argue that this is an extremely effective, evidence-based school improvement mechanism that is likely to bring about and embed cultural change in schools. Thus, this evidence suggests that the NHSS may act as a catalyst for change. The next section explores in more detail the issue of children and young people's participation, which can be seen as fundamental to effecting cultural change.

### 2.3 Children and young people's participation: the emergence of a concept

The United Nations Convention of the Rights of the Child (1989), ratified by the UK Government in 1991, expresses in Articles 12, 13 and 17, the rights of the child to express an opinion, have it taken into account in any matter affecting the child, and to access information relating to his or her social, spiritual and moral wellbeing and physical and mental health (Alderson, 2000). This is widely seen as the defining standard for all UK law and government policy and practice. The Children's Fund, for

example, has an explicit commitment to involve children and young people in the planning, delivery and evaluation of services (National Evaluation of the Children's Fund, 2005). *Every Child Matters* (DfES, 2003), the Government's Green Paper, emphasises the importance of early intervention to avoid educational failure, anti-social behaviour and improve health and wellbeing. It identified five outcomes, which are of relevance to the NHSP in general and, in respect of the fourth outcome listed, directly identifies the participation of children and young people:

- being healthy;
- staying safe;
- enjoying and achieving;
- making a positive contribution;
- economic wellbeing.

The *Children Bill* (March 2004) enshrines in legislation the duty of every agency, including schools, to work together, in partnership, to deliver these outcomes. Children and young people's participation is articulated as central to the delivery of these outcomes. From September 2005 schools will be required to demonstrate how they are contributing to the five national outcomes for children in *Every Child Matters* and the *Children Act*. Participation in a healthy schools programme and achieving healthy school status could be an important aspect of how schools evidence that they are working towards these outcomes.

### 2.3.1 The meaning of participation within the school context

The DfES has published statutory guidance on developing an ethos of participation in schools and local education authorities (DfES, 2004). The NHSS Level 3 criteria require schools to demonstrate that pupil participation is making a difference to the running of a school (HDA, 2004a). The NHSS has issued guidance on how schools can promote children and young people's participation within the context of a healthy school approach (HDA, 2004c). Ofsted also requires inspectors to report on how well a school involves its pupils in its work, including how it consults with and acts on their views (Ofsted, 2003). Thus, there are multiple drivers supporting this quite fundamental change in the way children and young people are involved in the life of the school.

Hagquist & Starrin (1997) point out that much of the empowerment debate has focused on adults and only somewhat belatedly been applied to children and young

people. They also point out that children's empowerment is linked intrinsically with their relationships with adults. They cite Hefner (1988) and Rissel (1994) who have argued that whilst empowerment has an element of self-activity, it is largely encouraged through the development of structures to enable participation. In schools, Hagquist and Starrin (1997) discuss the importance of an enabling school climate. However, as Scriven and Stiddard (2003) argue, whilst schools are suitable settings for promoting health and wellbeing, their tendency to be hierarchical means that there is limited scope for pupils to express their viewpoint. They argue that power has, traditionally been unequally distributed within school settings, with pupils often lacking control over what happens to them. Hine's (2004) research with children between the ages of seven and 15 reveals that their biggest complaint about school was that they were not listened to and they were sceptical about their schools' attempts to involve them. This suggests that whilst there is a strong policy commitment to participation, this might not always translate into everyday practice. However, the NHSS provides a possible vehicle for the empowerment of children and young people with the associated benefits for health and attainment.

Involvement, consultation and participation are all terms that are frequently used in respect of the rights of the child and the responsibilities of organisations. Arnstein (1969), Hart (1992) and Shier (2001) have all developed models for understanding the differing conceptualisations of these terms. Children of primary school age are particularly likely to be marginalised in consultative processes as they are often seen as immature developmentally and not able to contribute (Sinclair, 2004). The DfES (2004) articulates a model of participation that emphasises the importance of not only creating opportunities for pupils to express their views but also to be involved in decision making.

Within schools, there have been two recent developments that relate to children and young people's participation. Citizenship education became a National Curriculum foundation subject at secondary level in September 2002 and within primary schools citizenship, as part of the personal, social and health education curriculum, is subject to inspection (Mckenzie, 2004). The three strands to citizenship education are: becoming an informed citizen; developing skills of enquiry and communication; and, developing skills of participation and responsible action (HDA, 2000, p. 5). In terms of impact, there is some evidence to suggest that citizenship education has not only enriched the curriculum but has positively influenced school ethos and encouraged

schools to become more democratic, although there are some differences between primary and secondary schools.

The introduction of citizenship into the curriculum provides children and young people with opportunities to learn about the concept of citizenship. However, for Scriven and Stiddard (2003) empowerment is about participation, not simply learning about, for example, citizenship. The NHSS emphasises the importance of involving pupils in their healthy schools programmes in terms of "giving pupils a voice" (HDA, 2000, p. 3). This is specified in Standard 3.4.1 in terms of influencing the delivery of personal, social, health and citizenship education, taking responsibility for some aspects of school life, involving pupils in policy delivery and expressing their needs. This can be seen as complementary to the formal citizenship curriculum and as a means of encouraging children and young people to participate actively in school processes that can provide them with experiences through which they can learn about citizenship.

### 2.3.2 School councils: participation in action

The active participation of children and young people in school settings poses specific challenges for those charged with enabling it. Cotmore (2004) argues that school councils offer a possible vehicle through which participation can be facilitated, contributing and complementing the more formal teaching of citizenship in schools. There are now a number of drivers that are supportive of their development and the NHSS advocates the creation of a school council structure, linked into wider school processes of upward and downward accountability as an effective means of enabling active participation. However, research by Baginsky and Hannam (1999) found that school councils were more likely to be found in secondary than primary schools and recent evidence suggests that progress in primary schools has continued to be slower than expected (0-19, 2005). Madge, Franklin and Willmott (2003) found that the extent and form of involvement varied considerably from school to school and Wyse (2001) argues that the contemporary emphasis on standards deflects attention away from school processes that might facilitate democratic involvement.

Of importance to this study is the question of the extent to which children and young people's participation through, for example, a school council, can be linked to wider health and educational benefits. Alderson (2000, p.124) makes the point that they are a "symbolic indicator of respect for children's rights", with the possibility that this may of itself have beneficial consequences for relationships within the school setting and

the generation of a more pupil-centred, democratic ethos. Cotmore (2004) argues that school councils have become popular because they link with the behaviour management agenda. Thus, one possible consequence of having an effective school council is an improvement in standards of behaviour. There is some evidence to support this idea, and, furthermore, that improvements in behaviour can lead to a reduction in school exclusions (Davies, 1998). Osler (2000) argues that behaviour and exclusions are fundamentally connected to school improvement and the standards agenda. Creating structures through which children and young people can participate in the life of the school has particularly important potential benefits for those at risk of exclusion. Their alienation can be reduced by their active involvement in school processes (Osler, 1997). Osler's research (2000, p. 55) suggests that pupils see school discipline as closely related to "teacher-pupil relationships and to school structures which permit them to participate", including their involvement in decision making, which increased their motivation to achieve and made them feel part of the school. The Crick Report (Crick, 1998) cites evidence that suggests improved behaviour in primary schools is attributed by head teachers to having an effective school council.

School councils have also been shown to lead to improvements in school ethos (Taylor & Johnson, 2002). The mechanisms through which this can happen are likely to be varied. For example, improvements in standards of behaviour can directly contribute to improvements in school ethos through less explicit conflict and improving relationships between teachers and pupils. There may also be direct effects of school councils on school ethos because they can generate positive views and enthusiasm about school (Alderson, 2000). Participation can have a positive effect on achievement through improvements in motivation, developing a sense of responsibility and feeling trusted (Hannam, 2001). Osler (2000) also points out that school councils, if they are run along democratic principles, can lead to practical and tangible improvements of importance to pupils, such as refurbishing the toilets. If participation allows children and young people to express their concerns about life in schools and how they may be dealt with, then issues such as bullying can be actively addressed. Bullying has been shown to be one of the key factors in exclusion and lack of achievement (Healy, 2002; Healy, 2004) therefore, creating the conditions in which it becomes less prevalent is likely to have a significant impact on school ethos and school improvement programmes. Furthermore, evidence suggests that those young people on school councils develop skills such as listening and discussing, as well as feeling more able to take responsibility for themselves (Osler, 2000).

This research suggests that school councils can have a range of effects, not only for the participants but also the wider school community. This is particularly in terms of behaviour, exclusions and school ethos. These are indicators that are of relevance to school improvement. Furthermore, what this suggests is that the NHSS, through its emphasis on pupil participation and encouragement to schools to develop accountability structures such as school councils, can act as an important driver in creating the conditions within which children and young people can thrive. The concept of healthy settings has for some time been viewed as important in understanding how social context influences behaviour (Dooris, 2004; Whitelaw et al., 2001) and the role of the school climate has been noted in connection with school effectiveness (Hagquist & Starrin, 1997). This research evidence suggests that to understand mechanisms for school improvement and educational attainment requires an analysis of school settings as "complex networks of social relationships" (Dopson, 1999, p. 33). School councils might have the effect of shifting relationships between teachers and pupils and amongst pupils themselves in a direction that increases the school's capacity for change and improvement.

However, the extent to which such conditions can lead to improved health and educational outcomes is less clear. Research by Madge et al. (2003) concluded that there was no strong evidence to suggest that greater pupil participation was linked with increased school attainment scores. However, they point out that any changes in school ethos are likely to take some time to track through to improvements in achievement. The same is true of health outcomes. However, the HDA (2004a) has published research to indicate that participation can have a beneficial effect at the level of the school as well as on individual children and young people through improvements in school ethos, school improvement programmes, teaching and learning, inclusion, health and wellbeing and the reduction in inequalities.

The discussion so far has looked specifically at the role of school councils in encouraging participation and what the likely consequences of this might be. In order to more fully explore the impact of the NHSS on school improvement, the research evidence is reviewed in the next section.

### 2.4 School improvement and the National Healthy School Standard

There is an extensive literature on the development of the school improvement agenda at a national and international level, and it is beyond the scope of this study to explore it in any detail. However, what is of relevance here is to understand school

improvement as currently articulated in the policy and practice literature in order to understand how the NHSS may contribute towards its aims and objectives. It is thus the purpose of this section to briefly chart the main characteristics of school improvement. Wright (undated) points out that the Ofsted framework from September 2003 closely matches the whole school requirement for effective healthy school activity. All schools engaged in the NHSS are required to address a list of ten identified aspects of school life that contribute to general school improvement. From September 2005, Ofsted expects schools to demonstrate how they are contributing to the five national outcomes for children identified in *Every Child Matters* (DfES, 2003).

### 2.4.1 The development of the school improvement agenda

Reynolds, Hopkins, Potter and Chapman (2001) trace the emergence of the school improvement agenda from the late 1970s to its current manifestation in policy terms. They draw attention to the changing emphasis in the school improvement literature over the last 20 years in terms of:

- a move away from organisational change in school processes towards an increasing focus on pupil outcomes;
- increased attention on the competence and behaviours of teachers;
- increasing awareness of the importance of 'capacity building' through staff development and approaches to the management of change in terms of 'pressure and support';
- an appreciation of the importance of cultural change to embed a school improvement philosophy.

More recently the concept of 'school effectiveness' has also entered the literature. Stoll and Fink (1996) describe school improvement in terms of a set of processes targeted at both the school's ability to self-manage change as well as on pupil achievement. Thus, a focus on both cultural change (Beresford, 2000) as well as on quantitative data about pupil attainment has developed. Measures of school effectiveness have been defined in terms of attainment, absenteeism and exclusion. Within this context, improvement is defined as a change in effectiveness, as measured in attainment, absenteeism and exclusion.

A number of school improvement projects (for example, Improving the Quality of Education for All – IQEA) and strategies (such as Excellence in Cities and Education

Action Zones) have been developed and implemented with variable degrees of success, particularly in respect of schools in disadvantaged areas, where there are a disproportionate number of schools labelled as underperforming (Harris & Chapman, 2004). However, recent research indicates that whilst underperforming schools often share certain socioeconomic characteristics they underperform for a variety of reasons (Hargreaves, 2004). Harris and Chapman (2004, p. 420) argue that:

> However well intentioned these initiatives were, they failed to offer the differentiation of response that schools required, providing instead a standard response to an improvement problem requiring greater diversity, variability and flexibility.

Evidence suggests that the characteristics of schools that have succeeded against a background of significant disadvantage emphasise (Reynolds et al., 2001; Hopkins, 2001):

- a leadership stance which builds a team approach;
- a vision of success expressed in academic terms;
- a clearly articulated view on how to improve;
- improvement in the physical environment;
- common expectations about behaviour and success;
- investment in good relations with parents and the community.

What this research suggests is that school improvement programmes need to be compatible with each school's developmental needs (Harris & Chapman, 2004), and sufficiently flexible to enable effective integration, as well as offer the prospect of additional external support and resources. The similarity with the NHSS is evident here.

Evidence suggests however that there are also policy drivers that may limit the extent to which school improvement programmes are likely to be embraced. McNess, Broadfoot and Osborn (2003) draw attention to the erosion of the emotional dimensions of teaching as a result of the direction of recent education policy, specifically in respect of the National Curriculum and national testing, which have sought to emphasise accountability and raise school standards. Ainscow, Booth and Dyson (2003, p.14) found that the national policy context "shaped school practices … to exclude and marginalise some students and limit the experiences available to all."

Fullan (2000) emphasises the importance of organisational features in building a school's capacity to change and identifies professional learning community and

programme coherence as fundamental to effective change. Hopkins (2001) argues that schools, as complex social systems, tend to fragment and produce overload when presented with multiple initiatives to which they are expected to respond. Thus, effective schools are those that selectively take on innovation and integrate and co-ordinate it into a coherent programme.

## 2.5 Conclusion

Whilst the NHSS is not a school improvement programme, comparing the characteristics of schools that have improved with the NHSS framework, it becomes evident that there is considerable convergence in their characteristics. Furthermore, the NHSS framework can be understood in terms of developing the capacity for change at the level of the school and at the level of the child.

# Chapter 3
# Study design

## 3.1 Introduction

Deciding on an appropriate study design to explore change at the level of the school setting involved giving consideration to methodological, feasibility and resource issues. This chapter provides a description of the research strategy and data collection processes used in this study as well as a justification for them. It also provides a description of each of the case study sites in terms of the type of school and its catchment area, and the extent of its involvement with the local healthy schools programme. Some details are omitted in order to preserve the anonymity of schools.

## 3.2 Case study research

Case study research has considerable potential in the study of organisations (Dopson, 2003). This is particularly the case where the aim is to understand the implementation of a policy or an initiative and form judgements about its consequences (Keen & Packwood, 1995). Studying the consequences – intended and unintended – of interventions in organisational settings is complex and case studies typically use multiple methods – both qualitative and quantitative – in order to try to reveal this complexity (Bradley, Wiles, Kinmonth, Mant & Gantley, 1999). The use of qualitative approaches in particular are important in case study research as they have the potential to reveal in some detail "how and why the intervention succeeds or fails" (Keen & Packwood, 1995, p. 444) in real life situations where the researcher has no control over the situation being studied. Thus, case study research can generate explanations and understandings of why and how initiatives work within specific contexts (Bonner, 2003; Dopson, 2003; Judge & Bauld, 2001) and, furthermore, generate data that can be used to describe implementation, which is important if questions concerned with success and failure are to be addressed (Bradley et al., 1999). Case study research can also be useful when the intervention is complex, multifaceted and is implemented over time, as in the case of the NHSS. Case studies offer a way of studying an organisation as an integrated whole in terms of a social system, which focus on the patterns of relationships, interdependencies and interactions between the different 'actors' (Anderson, Crabtree, Steele & McDaniel, 2005; Dopson, 2003). Thus, change at the level of the organisation can be understood in terms of the interactions between the individuals. In this study, each

school was used as a case study for understanding the implementation of the NHSS and forming judgements about its consequences for school improvement.

### 3.3 Research aims

As indicated above, the focus of this study necessitated the formulation of quite precise research aims at the outset with data collection directed towards addressing them. The aims of the research project were to:

- understand the process by which the NHSS initiated change in identified schools;
- explore the consequences of change – intended and unintended – from a variety of stakeholders' perspectives;
- explore the relationship between identified changes and outcomes;
- reconsider the role of the NHSS in bringing about school improvement.

### 3.4 Selection of sites

This is an essential part of the process of case study research (Keen & Packwood, 1995). The original intention was to use an in-depth case study approach in six schools, two in each part of the County: west, east and central Cheshire. The two schools in each locality would be chosen on the basis of their position in the NHSS process, with one of the pair at the initial signing up stage and the second having achieved Level 3 status, with the NHSS framework embedded into the school. This would allow a prospective and a retrospective analysis to be carried out respectively. Identifying schools that met these criteria was not straightforward however. In part this was due to the success of the roll out of the NHSS in the County and in part due to a number of schools' reluctance to engage in the research because of other priorities at that time.

Working with the healthy schools development workers, ten schools distributed across the three different localities were approached and visited in order to explain the research and gain consent to participate. On the basis of this preliminary visit, four schools declined. In a further three schools, preliminary work started but was later abandoned because of changing circumstances and difficulties in gaining access for practical work within the timeframe for the fieldwork. This meant that, within the three localities, it was not possible to identify and engage in the research process schools that met the original criteria. This situation necessitated a review of

the selection of sites and a decision was made to study three schools in depth each at different stages of the NHSS process, and in different parts of the county.

### 3.5 Recruitment of schools

The researcher worked with each of the three healthy schools development workers to recruit the schools to the research project. All of them worked with schools in their locality to engage and support them in the process of achieving accreditation. The researcher was invited to attend a meeting with the healthy schools development worker and each school's healthy school co-ordinator to discuss the research. This was normally as part of the series of meetings that would be held between the two parties to discuss and review progress on the NHSS accreditation process. In some cases the head or deputy head teacher would also be involved in this first meeting. The teachers were given a copy of the research proposal, a participant information sheet (Appendix 2) and a consent form (Appendix 3). On the basis of this meeting, consent was either given or declined. If consent was obtained, a programme of work was agreed.

#### 3.5.1 School A

School A is a Local Education Authority maintained mixed sex junior school (seven to 11 age range) situated in central Cheshire. In 2005, there were 265 pupils on the roll. The proportion of pupils eligible for free school meals in 2000 (the year of the last Ofsted inspection report) was approximately 14% (36), which is above the county average (11.6% in 2005). The ethnic background of pupils is predominantly 'white' (97%) and the majority of pupils speak English as their first language. The Ofsted report of 2000 describes the school as oversubscribed, resulting in relatively large classes of between 30-35 pupils. The school is situated in an urban area and the ward in which it is situated is ranked 84 out of 442 (where 1 is the most deprived) for the index of multiple deprivation. This is in the top 20% for Cheshire.

The school began to think about joining the healthy schools accreditation scheme in November 2001 after discussions with the County Healthy Schools Co-ordinator. Active work on the scheme started in February 2002. Table 3.5.1.1 shows the priorities that were identified by the school as part of the accreditation process.

**Table 3.5.1.1 School A priority and target statements**

| NHSS theme | Priority standard | SMART target |
|---|---|---|
| Partnerships | The school has a clear statement of intent regarding the involvement of young people in the school. | To establish a school council. |
| Management of the scheme | The audit is used to identify priorities across the taught curriculum and within the wider context of the school community. | To carry out a survey of children's views of their school. |
| Developing work in school | Emotional health and wellbeing. | To make water available in classrooms throughout the day. |

Subsequent years have seen the annual use of the children's questionnaire to identify priorities for each academic year. The school was successful in achieving accredited healthy school status in April 2003. Healthy schools work is now described as 'embedded' within the school's policies and procedures, for example through the School Development Plan.

### 3.5.2 School B

School B is a mixed sex nursery, infant and junior school (three to 11 age range) situated in east Cheshire. In 2005, there were 214 pupils on the roll. The proportion of pupils eligible for free schools meals in 2002 (the year of the last Ofsted inspection) was approximately 33%, which is above the national average as well as the county average (11.6% in 2005). The ethnic background of pupils is predominantly white and most speak English as their first language. The percentage of pupils with special educational needs (19.7%) is broadly average. The school is located in an urban area. The area in which the school is located is ranked 149 out of 442 for the Index of Multiple Deprivation and is ranked 94 out of 442 for the Index of Multiple Deprivation children's domain.

The school began discussions with the healthy school development worker in September 2001 and actively began work on the scheme in the Spring of 2002. Table 3.5.2.1 shows the priorities that were identified by the school as part of the accreditation process.

**Table 3.5.2.1 School B priority and target statements**

| NHSS theme | Priority standard | SMART target |
|---|---|---|
| Partnerships | Young people are involved in the programme planning, delivery and evaluation. | Establish a school council.<br>Set up nurture groups. |
| Management of the scheme | Training for staff in drug education. | Complete training on drugs policy and practice for parents and governors. |
| Developing work in school | Developing a whole school awareness of, and approaches, to the environment. | Establish seating and shade areas.<br>Establish a recycling scheme.<br>Carry out a survey of children's perceptions of the toilets.<br>Establish different play areas in the playground. |

### 3.5.3 School C

School C is a mixed sex infant and junior school (four to 11 age range) situated in east Cheshire. In 2005, there were 160 pupils on the roll. The proportion of pupils eligible for free school meals in 2000 (the year of the last Ofsted inspection) was approximately 6%, well below the locality, county and national averages. The ethnic background of pupils is 97% white and most speak English as their first language. The percentage of pupils with special educational needs (19%) is broadly average. The school is situated in a predominantly rural area. The area in which the school is located is ranked 229 out of 442 for the Index of Multiple Deprivation.

The school began discussions in the summer of 2004 with the healthy schools development worker. Active work on the scheme began in September 2004, when the three priorities were identified. Table 3.5.3.1 shows the priorities that were identified by the school as part of the accreditation process.

**Table 3.5.3.1 School C priority and target statements**

| NHSS theme | Priority standard | SMART target |
|---|---|---|
| Partnerships | To gain information on good practice and pupil needs. | To become involved in the anti-bullying pilot project. |
| Management of the scheme | Whole school approach. | To put appropriate policies into place for PSHCE, anti-bullying and child protection. |
| Developing work in school | To create a safe and secure school environment for all. | To set up a buddy system in school. |

### 3.6 Data collection methods

Case studies typically use multiple methods for two important reasons. Firstly, using multiple methods means that emerging findings can be corroborated from different data sources through a process of triangulation, which in turn increases the validity of findings (Denzin & Lincoln, 1994). Secondly, using multiple methods allows a more complete picture of the organisational setting and the implementation of the initiative to be established (Dopson, 2003). For these reasons, this study used the following methods of data collection, elaborated in the following sections:

- semi-structured interviews with school teachers with a specific role in the implementation of the NHSS in their school;
- focus groups with school children;
- non-participant observation of activities that had been introduced as a result of the NHSS;
- documentary analysis of sources that had been produced as a result of the NHSS process, for example, the school audit, agendas and minutes from school council meetings;
- analysis of secondary data sources such as the latest Ofsted Inspection Report.

Whilst a number of data collection methods had been decided in advance of contact with each school, as described above, the precise activities varied from school to school as the picture of NHSS work became clear. However, the main purpose of all the different data collection methods was to try to capture evidence of change brought about by the NHSS process. The fieldwork was carried out between March 2004 and June 2005. A summary of data collection activities is presented in Table 3.6.1.

**Table 3.6.1 Summary of data collection activities in each of the schools**

| Data collection method | School A | School B | School C |
|---|---|---|---|
| Preliminary preparatory visit(s) to explore position in the NHSS process, gather background information, gain consent and agree focus of work | ✔ | ✔ | ✔ |
| In-depth interview with healthy school co-ordinator | ✔ | ✔ | ✔ |
| In-depth interview with head teacher | | | ✔ |
| Observation of meetings of the School Council | ✔ | ✔ | ✔ |
| Focus Group meeting with members of the School Council | ✔ | ✔ | ✔ |
| Observation of playtime and/or lunchtime activities | ✔ | ✔ | ✔ |
| Focus group meeting with children acting as 'buddies' | ✔ | | ✔ |
| Observation of meetings of the Healthy School Management Team | | ✔ | ✔ |
| Documentary analysis of key materials generated through the NHSS process | ✔ | ✔ | ✔ |

### 3.6.1 Semi-structured interviews with school teachers

In each of the three case study schools, the healthy school co-ordinator was interviewed. In School C the head teacher was also interviewed as she was the organiser of the school council. An in-depth approach was used in order to explore with interviewees a range of issues about the implementation and impact of the NHSS in the school in an open-ended way. The interview schedule defined in broad terms the areas to be covered and can be found in Appendix 4. With the permission of the interviewee, the interview was audio-tape recorded and subsequently transcribed verbatim.

### 3.6.2 Focus groups with school children

Two types of focus groups were held with children. In all cases discussion took place with the teacher present. The discussion was not tape recorded, rather detailed notes were taken, supplemented by additional reflections immediately after the meeting.

The meeting of the school council was used as an opportunity to set up a short focus group discussion after the main business of the meeting had been concluded. In

addition, the healthy school co-ordinator arranged focus group discussions with groups of between six to 12 buddies. The approach used in these meetings was informal, using open ended questions to explore children's views and understandings of their roles on the school council or as a buddy, how it had contributed to the life of the school and its impact on themselves. Children were encouraged to respond to each other's points and give examples to illustrate the issues they raised. A copy of the focus group schedules can be found in Appendix 5.

### 3.6.3 Non-participant observation of activities

Non-participant observation of meetings of the school council was carried out. Detailed notes of the proceedings of the meetings were made using the observation schedule in Appendix 6. The main purpose of the observation was to understand how the school council was run, including the dynamics of interaction beyond the school council to the classroom. Attention was given to describing the extent to which it was a vehicle for giving pupils a voice in how the school was run. A total of six observation sessions were carried out at the three schools (three in School A, two in School B and one in School C).

Non-participant observation was also carried out in respect of playtime and lunchtime activities. This also involved opportunities to talk informally to buddies who explained the activities and systems used. The observation schedule can be found at Appendix 7. In total, four observation sessions were held (two in School A, and one each in School B and School C).

### 3.6.4 Documentary analysis of sources

The following documents were accessed to gain an understanding of the NHSS process adopted in each school:

- information and data relating to the initial audit and questionnaire and the identification of priorities;
- agendas and minutes from school council meetings;
- agendas and minutes from healthy school management team meetings;
- copies of healthy school newsletters sent home to parents;
- information from other questionnaires carried out;
- completed documentation from the Cheshire Healthy School Handbook including presentation of evidence as part of the accreditation process.

### 3.6.5 Secondary data sources

Secondary data sources were accessed in order to build up a profile of the three case study schools. Data were extracted from the latest Ofsted report for each school as well as from the DfES performance tables. These two sources allowed data to be extracted in respect of five years. Comparison data at the level of the county was extracted from the Cheshire County Council education statistics website. Additional information about the catchment area of each school was obtained from the Cheshire County Council local statistics website.

## 3.7 Research ethics

Ethical approval for this study was sought in May 2004 from the Centre for Public Health Research Departmental Research Ethics Committee at the University of Chester. Approval was obtained in June 2004.

The study was based on good research practice, as defined in guidance published by the British Sociological Association (2003) and the British Educational Research Association (2004). The principle of informed consent guided the recruitment of schools and individuals to the study. Thus, although the research was commissioned by Cheshire Local Education Authority, the principle of voluntarism was adhered to in approaching all schools. Head teachers and healthy school co-ordinators were provided with a participant information sheet and a copy of the proposal.

## 3.8 Data analysis

In broad terms, there were three different levels to the analysis:

- 'testing' the broad hypothesis that there is a relationship between the implementation of the NHSS and various aspects of school improvement;
- developing and using a framework of concepts to guide the testing of the hypothesis;
- allowing for the emergence of other issues by adopting an exploratory and iterative approach to the data analysis so that 'unexpected' phenomena could be identified.

Thus, the first step was to develop an analytic framework of sensitising concepts that was used to facilitate the analysis and interpretation of findings, as suggested by Keen & Packwood (1995). This framework was derived from the review of the research literature relating to the impact of the NHSS and its possible relationship

with various aspects of school improvement. This literature was interrogated to distil a set of concepts that related to the purposes of the NHSS, the processes to be adopted as the school moved towards accreditation and the characteristics of an improving school. The framework of concepts is presented in Table 3.7.1.

The first approach to conducting the analysis involved using the framework to interrogate the data for each case study school separately. The second level of analysis involved combining the case study material in order to present an analysis of the schools as one data set. The approach was to identify themes and sub-themes that related to the research aims of the project. These were developed through an iterative process that involved the reading and re-reading of transcripts, fieldwork notes from observations and focus groups, and documentary material to create tentative categories of meaning (Strauss & Corbin, 2003) both within each case study and then across the full data set. This process was carried out until a coherent set of thematic concepts was established. Qualitative material from the observation sessions and the focus groups with children were integrated with the interview material in order to add detail, provide examples or verify the views presented through a process of triangulation. The interrogation of relevant documents was also used in this manner.

**Table 3.7.1 Framework of analytic concepts**

| Level | Criteria | Examples |
|---|---|---|
| School | Change in the physical environment | • Improvements to toilets, including buddy system to 'manage' difficult areas<br>• Decline in litter<br>• Productive activities provided at play-time and lunchtime, including wet playtimes<br>• Quiet area for those who want to read or sit and talk (shaded garden area)<br>• Training of midday assistants<br>• Training buddies to help manage the system |
| | Development and implementation of specific policies and strategies to manage behaviour actively | • Assertive discipline policy and strategy that is systematically and consistently implemented throughout the school, with a system of rewards<br>• Play and lunchtime playground activities<br>• Buddy system to support strategies |
| | Development and implementation of specific policies, strategies and structures to give pupils a voice and involve them in decision making | • School council<br>• Circle time<br>• Use of assemblies<br>• Use of questionnaires and suggestions boxes to gather children's views<br>• Information from children is analysed and used to identify school priorities<br>• Buddy system<br>• Involvement of children in parents evenings<br>• Involvement of children in policy development and review |
| | Improvements in quantitative indicators of effectiveness | • Attainment<br>• Absenteeism<br>• Exclusions<br>• Minor incidents at playtime and lunchtime<br>• Accidents |
| | Integration of different initiatives into a coherent whole using the NHSS umbrella | • Development and review of policies<br>• New initiatives considered by the healthy school management team and children consulted |
| Teacher | Improved relationships between children and teachers | • Decrease in major and minor incidents<br>• Decrease in exclusions |
| Children | Improved attitudes | • Increase in children volunteering for roles and duties, including those not normally associated with helping |
| | Improved skills | • Active participation in consultative processes |
| | Improved engagement with school | • Decrease in authorised and unauthorised absences<br>• Decline in use of learning mentors and other roles used to support children with their learning and attendance |
| | Improved feelings of safety, security and happiness at school | • Improvements in attainment<br>• Improvements in pupil profiles in respect of attitudinal, behavioural and predispositions. |

# Chapter 4
# Understanding the role of the National Healthy School Standard in initiating change

## 4.1 Introduction

If school improvement is about change, then it is important to understand how the NHSS might initiate change. This chapter explores this in respect of what kind of changes engagement with the healthy schools accreditation process stimulated, particularly as they related to the school improvement agenda, as well as seeking to elucidate the characteristics of the NHSS framework that were seen as facilitating change. The findings are presented in terms of the themes and sub-themes that were identified from the analysis. Anonymised quotations from the interviewees' transcripts are used to illustrate these themes. Additional comments are added from the observations, focus groups and documentary analysis. The chapter also contains some description of the activities that were the focus of the study in order to provide a more detailed picture of the settings.

## 4.2 The National Healthy School Standard as a catalyst for change

Rather than assuming that embarking on the process of healthy school accreditation had led to tangible change, the four interviewees' narratives were interrogated to explore this issue. All the interviewees talked about positive changes brought about by engaging with the accreditation process, such that the NHSS could be understood as a catalyst for change. It was possible to discern from the narratives three different dimensions to this theme.

Interviewees talked about the way in which the NHSS framework and process stimulated and enabled them to address existing problems about which they were already aware. For example, in all three schools bullying, and behaviour generally at playtime and lunchtime, was identified as an issue about which teachers were aware but which, up to that point in time, had not been coherently and explicitly addressed. All interviewees talked about this issue in terms of its impact on the children and the atmosphere of the school and the consequences for learning during classes. For example, one healthy school co-ordinator said:

> *'There was a lot of aggressive games going on … a lot of pushing and fighting … a lot of football that was very aggressive. So I began to think that what was happening was that this negative aura that was being created during this ten*

> *minutes, quarter of an hour, was having a very bad, negative effect back into the classroom. It clearly was affecting the progress that those children could make … wet playtimes were a complete nightmare.'* (001/04).

The requirement to carry out an audit (Section 2.1 of the Standards) to identify priorities across the taught curriculum and wider school environment provided a means of consulting with children on key issues via a questionnaire. All three schools had done this on an annual basis and directly used the findings from the survey to focus on issues that children had raised. An analysis of the questionnaire findings from all three schools revealed that children, at different points in time, had identified bullying at play and lunchtime and the quality of the toilet facilities as issues that caused them some concern. These were then identified as one of each of the school's priorities around which specific strategies were designed. Speaking to the buddies in School A revealed their thoughts on the matter:

> *'The playground's a lot calmer now because we sort out arguments and there are less accidents.'* (FG 003).

Interviewees also talked about the way in which engaging with the NHSS process provided the impetus to reflect on the use of existing resources, such as the playground. Standard 3.3 (developing the whole school awareness of, and approaches to, the environment) has a component 3.3.2 that directs attention towards considering different play areas for different activities in all weathers. All three schools said they were stimulated to review the use of the playground and consider how to better manage it as a school resource. It was evident that this was, at least in part, connected to the issue of playtime and lunchtime behaviour management strategies, as discussed above. For example, one healthy school co-ordinator explained:

> *'In establishing our aims we decided to focus on creating this safe environment for all because we wanted to focus on well being really, that was our priority. We had had some children talking about instances of bullying, nothing severe, but the word bullying was being bandied around rather a lot. So we decided to take the bull by the horns and address it and look at our playground provision because there had been a lot of changes as well in the playground: the millennium garden had been set up, we had established this quiet area, but all these things had been added on ad hoc … creating this wonderful environment but not really talking to the children about it and the purpose of these different areas. That was what we wanted to target with the buddy system and create this safe environment for the children outside because if you talk to children that tended to be where concerns were, especially at lunchtimes. So it was a way of promoting the whole ethos of*

> *the playground and re-establishing boundaries. I think a lot of boundaries had been let slip so we are in the throws right now of saying, right what do we want from our playground, what do we want to see out there, how can we use this buddy system to improve the whole playground for everybody really?'* (003/05).

The NHSS thus gave impetus to considering issues such as the development of a nature and/or science trail, the creation of quiet areas for those pupils who wanted to sit and talk, or read, and the development of a variety of structured play opportunities through the zoning of the playground. The quotation above also reveals that the NHSS framework not only gave momentum to review existing facilities, but that this was also done in collaboration with the children and with the aim of developing a whole school, coherent approach to playground provision.

In addition to being stimulated to consider existing problems and resources, interviewees talked about the ways in which it had stimulated them to try new ways of working. In some cases this was in a fairly straightforward way, such as the development of a new policy, such as an anti-bullying policy. Given that the healthy schools co-ordinators had become sensitised to this via their consultation with the children, this was a policy that had been prioritised in all three schools. Furthermore, the process by which this had been drafted was new because it involved the children in giving their views. One healthy school co-ordinator explained:

> *'… and then from that questionnaire the school anti-bullying policy was written that was then taken to the governors to be agreed. But it actually was written based on the original anti-bullying questionnaire. The bullying questionnaire took about, oh I don't know, six months to write because the questions were back and fro to the classrooms via the school council. And so it is quite a detailed, it was to get the wording exactly right.'* (001/04).

All four interviewees talked at length and in detail about they way in which the NHSS framework had stimulated them to consider how to involve children in the decision making processes of the school (Standard 1.2, Component 1.2.3; Standard 1.4). For all four teachers, this was a new departure that was directly brought about by engagement with the healthy schools accreditation process. The introduction of the school council, class councils, the use of circle time and whole school assemblies, as well as the introduction of buddying systems were described by children and teachers as examples of how children were consulted. Interviewees also explained that this enabled children's active participation in decision making processes, something which had not happened hitherto. In addition, the annual audit, usually via

a questionnaire to children, often developed by them (as illustrated in the quotation above), was central to identifying healthy school priorities. Interviewees' narratives also revealed that processes were developed to enable communication across the whole school. Thus, the formation of a healthy school management team as well as feeding back to teachers via staff meetings, meant that communication occurred both vertically and horizontally, which served to generate a whole school approach to healthy schools work. This is reflected in the following healthy school co-ordinator's comment when talking about why the school embraced the NHSS:

> *'She (the head teacher) was very much committed to everyone in the school pulling together. If you haven't got a healthy child or a healthy school or a healthy environment then the chances of the children learning go downwards, so she wanted to really focus on getting that theme running throughout the school, so we do look out for each other, so that everyone feels safe, everyone is as well as they can be, so learning can take off from there.'* (002/04).

These three different dimensions of considering existing problems, existing resources and different ways of working, illustrate the way in which the NHSS acted as a catalyst for change in the schools. The use of a clear framework of standards and components directed the healthy school co-ordinator and the healthy school management team to consider specific aspects of the curriculum and the wider school environment, including the nature of their relationships with children. It is evident from a consideration of the Cheshire Standards that much of the framework is concerned with process, that is, the way things are done, as much as what is done. In fact, the four interviewees' narratives were predominantly concerned with how things were done and only rarely were curriculum issues discussed. When teaching and learning came up as an issue of interest or concern, this was mainly discussed in relation to the school environment being conducive to learning and the child being predisposed to learn, rather than the subjects that were taught or the teaching and learning styles that were used – a point illustrated by some of the quotations above.

### 4.3 Characteristics of the National Healthy School Standard that facilitated engagement

It was evident from the interviewees' narratives that there were several characteristics of the NHSS framework that were viewed as important in both attracting them to the healthy schools accreditation process and in bringing about change. The NHSS framework is structured into three sections: partnerships; management; and delivery. The standards and components that are listed under

each of these sections systematically direct the healthy school co-ordinator, in collaboration with the healthy school management team of each school, to develop a whole school approach to their healthy school work. For all interviewees, taken together, the NHSS framework was perceived as representing a whole school ethos that was attractive, as explained by the following head teacher:

> *'So I just felt the whole ethos of the healthy school was really the sort of ethos that we are wanting to engender in our school.'* (004/05).

Interviewees also talked about the way in which the whole school approach enabled them to make consistent links between the curriculum and the wider school environment. For example, one healthy school co-ordinator talked about the importance of not just teaching citizenship in the classroom but also in relating to children in a manner that was consistent with the issues that were covered:

> *'If you just teach it in PSHE lessons for half an hour, you know it isn't going to work because if they don't see that the lesson on being friendly and what is it to be angry actually then works in real life, then that is how it is all played out. So O.K. we discuss it in class and we are talking about these different qualities that make a, what is it to be a team, then they go and play that out in real life outside in the playground.'* (001/04).

This idea that the NHSS framework conveyed a description of a process by which an attractive school ethos could be generated, was articulated in three different ways by interviewees. Firstly, they talked in general terms about focusing on things and joining things up in the sense that the links between the different initiatives and issues could be established and worked on. For example, one healthy school co-ordinator said that:

> *'Healthy schools work underpins all the other things that go on.'* (002/04).

Secondly, they talked about being inclusive in terms of seeing children in particular, and parents to a lesser degree, as an integral part of the school community. In relation to children, this was explained in terms of involving them in consultation through a variety of mechanisms – through the questionnaire to collect information on their views, through the school council or other participative processes that schools might have developed. Furthermore, this involvement of the children was articulated as contributing a very important perspective to the policies and operations of the school, as explained by this healthy school co-ordinator:

> *'We wouldn't necessarily have developed playtime in the way that we have because that came from myself and the children combining to know what was good for a playtime.' (001/04).*

Thirdly, they talked about the way in which the NHSS was based on a very broad concept of health, based on the whole child and which included the social and emotional as well as the physical. All interviewees gave a very clear explanation of the links between the happiness and health of the child and the environment, and the way in which these factors influenced learning. This conceptualisation of learning in particular made the NHSS attractive, as the following quotation illustrates:

> *'… when I unpicked it - now this is only my analysis of what healthy schools means to me, this is nobody else telling me this - I drew a little diagram of three circles crossing, the mind, the body and the environment and in the middle there is learning because that is what school is all about.'* (001/04).

These characteristics of the NHSS framework were seen as bringing together issues which were hitherto perceived as unrelated into a coherent whole that made responding to different initiatives easier because the NHSS was seen as the unifying umbrella under which a lot of work could be embraced and organised. Thus, the NHSS can be understood, from the point of view of these interviewees, as revealing to them the connections between the different aspects of a school's work and ways in which they might be joined up. This might mean that it is less likely that schools become overwhelmed by initiatives.

Whilst the framework might be perceived as prescriptive, interviewees expressed the view that it was possible to adapt it to the particular school, and moreover, that it stimulated the school to view healthy school status as a process of continual reflection and review. This was made possible because of the emphasis on school processes that allowed them to be embedded into the culture of the school, rather than simply be bolted on to existing ways of working. One healthy school co-ordinator said:

> *'You would need somebody to take a whole view of it and maybe it wouldn't run as smoothly as it runs now but I would say that it has become so much part of school life now, as long as the other teachers were prepared to take on individual aspects … I can't see it disappearing.'* (001/04).

There was some evidence in interviewees' narratives that suggested that the NHSS might more easily fit with some schools than others. For example, when asked what

had been achieved since the school had started on the healthy school accreditation process, one healthy school co-ordinator said:

> *'We have actually done quite a lot, which speaks volumes as to where the school was at the start …you weren't pushing a boulder up a hill … the attitude was already here.'* (002/04).

This suggests that some schools might have characteristics and values that are consistent with the NHSS, but that this might not apply to other schools. Nonetheless, the NHSS as a organisational developmental tool gives it an element of flexibility such that it enables a school to devise a programme of work based on the school's assessed needs, as seen through the eyes of the children and teachers. The blend of prescription and flexibility of the NHSS was commented on by teachers as a valued aspect of the framework.

When interviewees were asked if some of the changes that the NHSS had lead to would have happened anyway they all were all emphatically of the view that they would not, as illustrated by the following quotation:

> *'I would say, absolutely not. It needs a person like myself who is a driving force behind it constantly. The children need to see that I proactively deal with things. Now as the system becomes better, the less I have to do. But if something arises like somebody gets their name in the buddy book then I must be seen to act upon it. It doesn't matter whether it is a pain for me, I must be seen to do it and this would not have happened because I wouldn't have set up the school council, the children wouldn't have the voice that is so very strong in school now. So I am an adult perceiving what is good at a playtime. The children telling me what is good at a playtime is completely different.'* (001/04).

# Chapter 5
# Understanding the impact of change

## 5.1 Introduction

Interviewees were asked for their views on the consequences of the changes that had been introduced as a result of embarking on the NHSS accreditation process. This question was used to explore, in particular, their views on the consequences for school improvement. It was possible to discern two levels at which consequences could be understood, namely, at the level of the school and at the level of the individual child. It was evident from the way in which both teachers and children spoke about these issues that they were inter-related, mainly through the interactions of teachers and children in the normal everyday life of the school. A prominent theme that emerged from the interview data was that involving children in school processes, through the school council and the buddy system for example, was one of the most important aspects of the changes that the NHSS had brought about, and moreover, a development that would not otherwise have been embarked upon. Furthermore, it was evident from all interviewees' narratives that consulting and involving children was the foundation from which better standards of behaviour and an improved school ethos would develop. For these reasons, much of this chapter focuses on the participative processes that schools had developed to involve children, and presents the children's and teachers' views on their involvement in the life of the school. Firstly however, some description is given of the ways in which the school council and the buddying systems were set up in the three schools.

## 5.2 Processes for giving pupils a voice

All three schools had set up a school council and had introduced various playground management strategies and buddying systems as a consequence of engaging with the healthy schools initiative. The extent to which these were embedded within the operations of the school varied in relation to the amount of time the school had been engaged in the NHSS accreditation process. Thus, School A described these processes as *'embedded'* (001/04) into the life of the school, whereas for School C, these structures were relatively newly established.

### 5.2.1 The school council

Schools had different mechanisms for children becoming members of the school council: teachers chose children in one school, house captains were members in another and children could volunteer in the third school. All three schools involved two child representatives from each and every class. Schools also had different ways of organising the business of the school council. In School A, the healthy school co-ordinator facilitated the business in conjunction with a nominated (child) chairperson and secretary. These roles were not so apparent in the other two schools where the teacher (head teacher or healthy school co-ordinator) was more involved in the co-ordination of the meeting. However, it should be noted that of the three schools, School A had been involved with the healthy school programme the longest.

From the observations and analysis of the agendas and minutes of school council meetings it was ascertained that the school council members had contributed to the following activities:

- contributing to the development of school policies;
- contributing to the development of school audit questionnaires;
- discussing findings from school audit questionnaires;
- formulating solutions to issues that had been identified in school audit questionnaires;
- feeding back to their class on the business of the school council;
- consulting with their class on matters of importance to be brought to the school council for discussion;
- reviewing initiatives that the school council had been involved with;
- giving their ideas on how the school might respond to a new initiative;
- choosing equipment for the playground.

Together these activities reflect the different ways in which pupils were given a voice within the school setting through the school council and reflect a spectrum of participation from consultation at one end, through to involvement in decision making processes and taking responsible school roles at the other. The school council process enabled a whole school approach to children's participation to be generated though horizontal (between pupils and other pupils) and vertical (between pupils and teachers) feedback mechanisms. The use of class councils, circle time and whole school assemblies were integral to this process.

### 5.2.2 Buddying system

Two schools had developed buddying systems, both of which were integral to the playground management strategies. In School A, the buddying system had developed into a complex system of seven teams of buddies, responsible for different aspects of the school. In School C, the buddy system was in the early stages of development, with a team having been established, trained and, at the time of the fieldwork, having been active for half a term. In School C children volunteered to become buddies. In School A, there was an established and formal process for applying to become a buddy as the following quotation explains:

> *'And I then asked the whole school from year three to year six to apply for the jobs and I did a proper application form. And they had to write me a letter of application that they had to do at home … and then I did formal interviews asking them particular questions about how they would deal with certain things, what was going to happen in certain scenarios.'* (001/04).

In both schools the playground school buddies worked with the healthy school co-ordinator and took responsibility for the management of the playground. Observations and focus groups with buddies revealed that they were involved in the following:

- sorting out arguments;
- playing with the infants, and other children;
- teaching other children new games;
- taking responsibility for putting equipment out and collecting it back in;
- befriending those who had no-one to play with.

For example, one buddy said, when asked what they do:

> *'If you have an argument come to me and I can listen … you can trust me … I am here to help.'* (FG 003).

Another buddy added:

> *'Yes, and we got together and looked at the catalogue and chose some things for the playground that we can play with.'* (FG 003).

## 5.3 A school environment that is conducive to learning

When teachers talked about the school environment they talked about it in terms of the physical environment and in terms of the ethos of the school. Analysing the explanations that the four teachers gave when talking about creating the right school environment for learning gave insight into their views on how the NHSS contributed

to school improvement. Problem behaviour – in terms of bullying, aggression, fighting and squabbles – was expressed as being an everyday problem that was disruptive and unsettling to children and teachers. Minor and major incidents eroded class time, upset children and raised the negative emotional burden of the school such that the teaching and learning process was undermined. The regularity and frequency with which events took place was seen as wearing and distracting to teachers and made many children feel unhappy and unsafe during playtime. For example, one healthy school co-ordinator said:

> *'Before it was like a battle ground at the beginning of each of the lessons because you know, you are saying – you shouldn't have been doing that at playtime or whatever – and so you are dealing with all of that instead of saying, right, the objective for today's lesson is, in a nice calm manner. Now, everybody comes into the classroom in a nice, calm way.'* (001/04).

Whilst the three schools varied in the extent to which they saw this as a problem in their particular school, they all talked about the negative consequences of poor behaviour at playtime and the way in which the NHSS gave them a vehicle for creating strategies for the better and more proactive management of behaviour. All interviewees thought that discipline within the class was probably well dealt with through, for example, an assertive discipline policy. However, all thought that there was 'carry over' of playground problems into the classroom. This was therefore, one of the main ways in which they expressed the link between the NHSS, the school environment and school improvement, namely, through the development of better behaviour management strategies that would raise standards of behaviour, decrease playtime and lunchtime accidents and incidents and create a calmer environment, and an ethos more conducive to effective learning. The following quotation illustrates this point:

> *'… if you can let people be in a secure emotional state and happy then you are enabling them to learn much more readily than if they are upset.'* (001/04).

For the school that had been working with the NHSS for some time, the healthy school co-ordinator's view was that this had already led to tangible improvements. For example, one interviewee remarked on the way in which playground incidents had declined since the introduction of the playtime strategies, going from *'about six a day and now hardly any',* as she elaborated*:*

> *'Before we were constantly – when we were on duty, it was a very tiring experience – constantly going around dealing with incidents, dealing with accidents … I can't remember the last*

> *time I dealt with an incident during playtime whilst on duty as a teacher. It is just dramatic.'* (001/04).

The management of the physical environment was described as being important in the effective management of children's behaviour at playtimes. In terms of the playground resource, as indicated above, the use of zones to structure the environment and a system of trained buddies to befriend young or vulnerable children and support the activities, including taking responsibility for play equipment and reporting incidents, was described by the four teachers and was evident during the observation and from talking to buddies. In one school the training of midday assistants lent additional support to the playground management strategy. One healthy school co-ordinator said:

> *'Our outside playtimes now we actively encourage people to play across the year groups and you will see all the year groups playing together very, very happily because it is constructive and it is supportive and it has got a general framework in which they can play happily together whatever the game may be.'* (001/04).

Buddies also verified this point. Observations revealed playgrounds that were full of active children participating in a range of structured activities that were zoned across the playground area, together with groups of children who wanted to talk and read. There were examples of buddies befriending other children, as one buddy explained:

> *'We're not bored now 'cos we can play games with the infants … and we listen because we are a friend to sort out arguments … I think the infants are a lot happier now.'* (FG 003).

Interviewees at two schools identified the toilet areas as where incidents often occurred that frightened some of the younger children in particular. The better management of these areas had been identified as a priority for attention, following responses of the children to a questionnaire. In one school, this was approached through using a system of community action volunteers (a team of buddies), which meant that incidents were better managed, or even prevented, as explained in the following quotation:

> *'The community action team now are split into seven different teams: litter team, school time team, toilet team, clean team, healthy eating team, computer team and "what's on" team. So this is a new thing from this year and community action has really grown tremendously. So they look after the environment of the school. If you have got problems in the toilets, you know when they are putting soap on the mirrors and stupid things; they are the people that clean. They get*

> *rubber gloves and they put their little signs out and whatever and they are very proactive on that.'* (001/04).

Two aspects were described as being integral to the effective management of these systems. Firstly, the involvement of children who had key roles in managing the system was seen as important. For example, in School A, where the community action volunteers were responsible for the toilet areas, involving even 'problem' children was seen as effective, as illustrated by the following quotation:

> *'And so they would have been the people who would have been vandalising, I put them in charge of people not vandalising and woe betide anybody who went against what they were doing. That has become quite a strong set of people.'* (001/04).

Secondly, the proactive dealing of issues by the healthy school co-ordinator as they emerged was also described as essential by all interviewees, as the following quotation illustrates:

> *'The bullying questionnaire that we did, the very first questionnaire that we did which was called something like, "what do you think?", it was something as basic as that, was based on the healthy schools questionnaire and because from that moment on the children saw that I responded properly and proactively in real terms to what they told me, then it works. If you play lip service to it, it doesn't. If you pretend it is working it doesn't.*' (001/04).

In School C, one buddy said:

> *'Mrs X (the healthy school co-ordinator in charge of the buddy team) helps us sort things out and we've also had training with Mrs X and we meet every Thursday with her to see how things are going.'* (FG003).

Interviewees also talked about the way in which pupil participation in decision making processes enabled a different kind of relationship to be forged between teachers and children. Thus, these participative processes, created opportunities for teachers to enter into a dialogue with children. One head teacher explained:

> *'So it is to do with honesty really and listening to them. Trying to make some of what they wanted to happen, happen so they could see they have had an impact.'* (004/05).

This was seen by one of the interviewees, a healthy school co-ordinator, as providing opportunities for explanation:

> *'We wanted them to understand why decisions are made.' (002/04).*

### 5.4 Children who are predisposed to learn

The more effective management of behaviour as described above was seen as contributing to creating a safer and calmer school environment, making children feel less anxious and better predisposed to learning. However, the four interviewees also talked about the extent to which developing strategies for pupil participation had also had an important impact on children. The two developments that were discussed by interviewees in some detail were again the work of the school council and the system of buddies.

Whilst there was variation from school to school in the precise detail of how they operated these systems, the focus of the analysis was on generating insight into how teachers understood the impact on children of their involvement in the school council or buddy team. Interviewees and children talked about the different attitudes, skills and behaviours they had developed as a consequence of taking on one of these roles. One healthy school co-ordinator gave an example of the way in which participative processes benefited both those with responsible roles as well as those who were involved in a more passive way:

> *'You have got two seven year olds teaching 30 children with no intervention from the teacher … them being empowered to stand there and, furthermore, the children responding to that with the right frame of mind.'* (001/04).

Interviewees all expressed the view that involving children in positions of responsibility – be it as a school council member or as a buddy – would lead to a range of positive outcomes for them. For example, they thought that children would learn to take responsibility for themselves, their views and actions, learn the skills of participation, discussion and decision making and benefit from improved self-esteem and confidence. Children also expressed similar views. For example, when asked what being on the school council had meant for them children replied:

> *'I used to be quite bossy but I've calmed down a lot now … I like to ask people things and I used to go on forever but I don't anymore, I listen.'* (FG001).

> *'I'm quite a good leader but I also like to listen and share ideas.'* (FG001).

The long term impact of involving children in participative processes, particularly those who took on positions of responsibility, was also articulated by all interviewees, as the following quotation illustrates:

> *'It is quite a long process to teach them how to become responsible children. I am certain that the things that they*

> *have been through here will be with them for the rest of their lives. They have been through interviews, they have been through applications and they are developing very, very strong people*.' (001/04).

The interviewees also articulated the view that there were wider benefits associated with adopting systems for giving pupils a voice. Improvements in children's relationships with teachers and school generally were seen as likely given that children were consulted and their views valued, and that they were enabled to contribute to the life of the school. Given that all three schools had developed the school council system to include mechanisms for feeding back to, and gathering views from their fellow pupils via class councils and/or circle time and/or assemblies, the impact was seen to ripple out beyond the council to the whole school. The cumulative effect of these impacts was seen in terms of children being more engaged with school life, one further consequence of which might be improved attendance, a decline in authorised and unauthorised absence and a decline in exclusions. Taken together, children were seen as being more engaged with the school and more predisposed to learning, as the following quotation illustrates:

> *'You would say that they are more open to take on the independence of learning. Instead of it being done to them, they are happy to take decisions, make decisions, be part of teams, talk together, discuss.'* (001/04).

# Chapter 6
# School improvement reconsidered

## 6.1 School improvement: attendance, exclusions and attainment

The current performance indicators for schools that are routinely collected and published by the DfES are attendance, exclusions and attainment. As part of the background to this study the data on these indicators were reviewed for each of the case study schools, with some comparison with the data for the county of Cheshire as a whole, and national averages. If the impact of the NHSS was measured in terms of these three indicators, then, in simple terms, since its introduction, these indicators would be expected to show improvements: a decline in the number of exclusions and authorised and unauthorised absences and an increase in the proportion of pupils at National Curriculum Level 4 or above in English, mathematics and science. In addition, in 2005, Ofsted published information on the introduction of the PANDA (performance and assessment report), which contains information about the make-up of a school, the standards of attainment and the progress that pupils make (Ofsted, 2005). The PANDA contains contextual value added (CVA) information, described by Ofsted as the main indicator of a school's performance, since it takes into account a range of important factors that affect the progress of pupils. This, and related developments by Ofsted and the DfES in online school data such as the Pupil Achievement Tracker (PAT), have been introduced to help schools complete their self-evaluation for the revised Ofsted inspection regime. The introduction of a more comprehensive range of indicators may be helpful in assessing the contribution of the NHSS. However, whilst these objective measures of performance might be useful in studying trends over time, caution should be exercised for the reasons outlined earlier in this report, particularly in respect of attributing any trend towards improvement in terms of a causal relationship with the NHSS. However, the data might usefully be analysed at a County level to examine both trends and differences between schools in respect of their accreditation status. The remainder of this chapter discusses school improvement as conceptualised and articulated by the interviewees.

## 6.2 The National Healthy School Standard and school improvement: interviewees' perspectives

In talking directly about school improvement, interviewees' narratives revealed a sense of realism about what engagement with the healthy school accreditation

process might lead to as far as each individual child's attainment was concerned. All interviewees expressed the view, with confidence, that the NHSS had a relationship with school improvement. However, in describing the interviewees' views in terms of 'realism', it was possible to tease out two dimensions to this understanding. Firstly, interviewees expressed the view that from the perspective of the Government, school improvement equated to improved Standard Assessment Test results. However, their view was that the NHSS was likely to impact on factors more concerned with the immediate learning environment, and that this, in turn, would track through to improvements in attainment, as the following comment reveals:

> *'Government school improvement would be higher SATS results but maybe if the teacher's time isn't taken sorting out disputes and if they could get straight to lessons, a proper start is always good. In others ways I am sure if children are happier - those who are susceptible maybe to not being happy on the playground or feeling that they are being picked on - if they feel happier then obviously they are going to perform in terms of Government performance.'* (004/05).

Secondly, whilst confidence was expressed that the NHSS led to beneficial effects in terms of school improvement, interviewees expressed the view that there were very real problems in measuring this. One healthy school co-ordinator said:

> *'… it does have knock on effects … how you measure it exactly I don't know, but I think the school would be a poorer place if we didn't have it.'* (002/04).

When asked to elaborate on the way in which they thought the NHSS could lead to school improvement, interviewees expressed the view that it had a multitude of consequences that, together, meant that children were happier and more predisposed to learn. They articulated the view that the NHSS was a vehicle for helping them create a physical, social and emotional environment within which children could flourish. This view is encapsulated in the following quotation from a healthy school co-ordinator:

> *'I would say that it has a very powerful effect on school improvement in all realms. It has a powerful effect in just very basic academic terms because the children are more ready to learn and we are enabled to teach because we don't lose time at the beginning of each lesson. The children have the right mind set because they are having a more relaxed, not roller coaster, playtime, so therefore they are more open for learning. Therefore more of the day is likely to be involved in productive teaching and learning scenarios than were the case. School improvement in terms of developing the children in different ways other than academic has been massive.'* (001/04).

Central to the idea that the NHSS was a vehicle for creating an environment conducive to learning was the view that by consulting with children and enabling their participation in school processes, they would feel more valued, more engaged with the life of the school, which included taking some responsibility for their learning, as discussed above. One healthy school co-ordinator gave a specific example of how children had initiated a change that resulted in increased opportunities being available for learning to more children:

> *'We used to do booster classes for just one set of children after school, now we do booster classes for all the different levels. Now that came from the school council saying to us, we don't like just that set of people having it after school, just for them. We all want to do it. Well for goodness sake, I would call that dramatic in terms of school improvement because the level 5s want to improve, the level 4s want to improve.'* (001/04).

Explaining how the NHSS was a vehicle for school improvement was also articulated in terms of the fact that it was underpinned by a broad concept of health, which looked at the whole child and her/his development. Thus, developing happy and healthy children could be understood as a necessary prerequisite to effective learning. For example, one healthy school co-ordinator said:

> *'O.K. I know our SATS results matter, yes of course they do, but also making well-rounded children, because well-rounded children are more able to apply themselves to their own learning and it isn't done to them, they are part of the process.'* (001/04).

### 6.3 Conclusion

What this discussion illustrates is the pressure on schools to demonstrate tangible improvements in educational attainment that are linked to specific initiatives such as the NHSS. The interviewees' perspectives outlined in this chapter revealed a more complex understanding of the link between outcomes and interventions. They understood school improvement in terms of engaging children in the life of the school through an environment and ethos that was inclusive, safe and welcoming, which in turn could lead to improvements in attitudes and behaviour and a developing predisposition to learn.

# Chapter 7
# Discussion

## 7.1 Limitations of the research

Capturing change in complex organisational settings is always difficult, particularly where there is the intention of trying to attribute specific outcomes to certain initiatives. Case studies offer a possible way forward but sometimes suffer from generating considerable detail. The practical aspect of doing research in naturalistic environments also poses difficulties in terms of negotiating access to particular case study sites. The original intention of this study was to employ a retrospective and prospective approach to capturing change at the level of the school setting. This would also have involved a larger number of schools. Arguably, this may have generated a more comprehensive evidence base that might have contradicted some of the findings presented here.

Overall, the findings from this study are very positive about the NHSS. None of the fieldwork generated negative views or perspectives. The different types of data – interviews, focus groups, observations and documentary analysis – consistently and coherently verified the emerging themes and sub-themes. However, it may well be the case that, by talking to teachers who were less directly involved in the NHSS for example, negative views may have been elicited. What did however come through was that the NHSS was hard work, but that the teachers valued it.

The main value of the case study is in terms of explanation, which is the primary purpose of this chapter. Thus, the following sections explore some of the mechanisms through which the NHSS and school improvement may converge.

## 7.2 Understanding how the National Healthy School Standard can lead to school improvement

At one level, the NHSS can be seen as prescriptive in that it sets out a requirement for all the Standards and sub-components to be evidenced if schools are to achieve healthy school status. However, the way in which it is precisely operationalised within a school is, to some extent, dependent on the people with whom, and the context within which, the initiative is operationalised, in terms of the following layers:

- the local context, for example, the strength of the local accredited health and education partnership and the kind of support offered;

- the organisational context, for example, the type of school and the needs generated by its circumstances; and,
- the individual practitioners, for example, the enthusiasm of the healthy school co-ordinator and the head teacher in respect of their capacity and capability to translate the principles and process of the NHSS into practice.

This blend of contextual layers (Dopson, 2003) means that the NHSS, as a policy initiative, gives schools the advantages of a guiding framework that focuses on key topics and issues, whilst at the same time enabling schools to embark on a process that can meet their needs and circumstances. Furthermore, it is based on a process that requires engagement with all key stakeholder groups, particularly children and young people, and stimulates a cycle of consultation, analysis and reflection, addresses issues at the level of the whole school and provides a framework for integrating additional policy initiatives coherently. These features of the NHSS align it to a large extent with the school improvement literature, as outlined in Chapter 2. To this extent then, the NHSS could be viewed as a school improvement initiative.

The emphasis on process within the NHSS requires schools to focus on *how* things are done, and this is particularly reflected in one of the cornerstones of the initiative, namely, giving pupils a voice. In order to understand *how* things are done it is necessary to consider what Dopson (2003) calls social processes, namely, the interactions and interdependencies between teachers and pupils. Thus, from a process point of view, schools can be understood as complex social settings defined by a web of dynamic relationships between teachers and pupils. The way in which these are 'played out' in schools – more or less democratic, or more or less power neutral – has implications for the kind of ethos that can be generated within the school. This in turn, can have a range of ramifications relating to individual child attitude and behaviour on the one hand and the school's behaviour management strategies on the other. If schools commit to giving pupils a voice through various participative structures, then the balance of power between pupils and teachers can, to some degree, be shifted in the direction of children. The evidence in this study indicates that, whilst there was variation in the way children were involved in the life of the school, there were genuine attempts to involve the children in various aspects of consultation and decision making and moreover that, from the point of view of children and teachers, this had positive consequences that were felt beyond the school council. The introduction of structures into the school setting to enable participation should be noted. Effective empowerment and inclusion of children and

young people within the school setting has been linked to structural changes (Hagquist & Starrin, 1997). However, it should also be noted that the predispositions and skills of teachers are critical to the realisation of children's participation within school. Some authors have also drawn attention to the fact that the risk of exploitation may be increased if consultative structures are used to manipulate children rather than empower them (Cooper & King, 2006). Furthermore, it is worth noting that empowering children within schools may have consequences for teaching and learning within the classroom and for relationships between children and their parents within the home.

Collectively, the changes that the NHSS evidently brought about had the consequence of developing the school as a context that was both receptive to change (Anderson et al., 2005) and conducive to learning. Moreover, change at the level of the school was best understood in terms of the interactions between individuals.

### 7.3 Is the National Healthy School Standard a vehicle for school improvement?

The question still remains about whether or not creating a context that is both receptive to change and more conducive to learning, can lead to harder outcomes of school improvement: improvements in attendance, exclusions and attainment. Certainly in the minds of the teachers involved in this study, this was their understanding. However, the purpose of school was viewed in broader terms than purely educational by these teachers, in that the NHSS was seen as having a role in developing well rounded children and young people, important in its own right. For primary schools this is perhaps particularly important in terms of influencing children's potentialities. There is also a common sense appeal to explaining the impact of the NHSS in school improvement terms through its influence on the school environment and ethos, which in turn track through to positive attitudes and behaviours, but perhaps it is important to tease this out rather more, as the following section attempts to do.

#### 7.3.1 Reconsidering the role of behaviour management in school improvement

All three of the case study schools used their involvement with the NHSS to develop and implement behaviour management strategies. The two main aspects of this were the development of an anti-bullying policy and the implementation of playground

management strategies. Both of these developments were facilitated by and involved the children and young people, to varying degrees, primarily via the school council. Drawing on the research evidence presented in Chapter 2 it is possible to consider the likely consequences of these developments.

Ofsted (1999) and the DfES (2001) have drawn attention to the importance of developing high trust relationships between teachers and children, which are encouraged by a democratic environment, in promoting children's mental health. Research by Weare and Gray (2003) indicates that the development of resilience in children is likely in schools that have a strong emphasis on anti-bullying and behaviour management. This suggests that schools that have strong policies, which are proactively implemented and underpinned by positive teacher-child relationships, can contribute to the development of a culture and ethos that supports the social and emotional health of children and young people (Healy, 2002; 2004). This is a reminder that culture and ethos are actively created on a day to day basis within the school setting through the dynamic relationships between children and teachers. Thus, a school ethos that explicitly values its children and cares for them can contribute directly to the development of resilience and positive mental health. The likelihood is that children will be more predisposed to engaging with school, with the possibility of actively contributing to their academic and non-academic development. Hammond and Fernstein's research (2006) suggests that it is not only academic achievement that matters in terms of understanding children and young people's trajectories into adulthood. Rather, the extent to which children have been engaged with school appears to have important ramifications for their life chances.

This analysis, although somewhat theoretical, has particular resonance for Cheshire schools. A study in 2004 (Mega-U, 2004) revealed the nature and extent of bullying in a sample of Cheshire schools. This research also showed that many children thought that their teachers held them in low regard. Furthermore, the nature of bullying reported was wide ranging and, in some schools, perceived to be a regular occurrence. However, those schools which gave bullying a high profile were perceived to have fewer problems than those who did not. Given the fact that the experience of bullying is a major factor in undermining individual health and wellbeing as well as the ethos of the school, strategies to manage its occurrence, as revealed in the three case study schools, are likely to lead to beneficial outcomes.

This reconsideration indicates that policies and practice are inter-related and can make a difference to the life of the school because they are the mechanism through which values and priorities are transmitted. This may go some ways towards explaining the role of the school in effecting positive health and educational outcomes, particularly for those children and young people who are most at risk of exclusion.

### 7.4 Conclusion

The findings from this study generally support the notion that the NHSS can be a vehicle for school improvement. However, there remain a number of challenges. Firstly, it will be important to find ways of engaging those schools who are perhaps reluctant to consider the NHSS as a school improvement initiative – for example, those facing challenging circumstances – as they are likely to be the ones that have most to gain from it. In line with many policy initiatives that involve the management of change, the school's capacity to deliver change is dependent on winning the hearts and minds of those charged with owning and delivering policies (Fullan, 2003). Secondly, finding more sensitive and specific ways of measuring the impact of the NHSS would be valuable. Given the strategic aims of the NHSS, its impact on health outcomes may be better viewed in the long term given the relationship between educational achievement, income and health. However, the impact on outcomes such as attendance and lifestyle might be seen as appropriate short term indicators. Whilst it is likely that pressure from policy makers nationally and locally will be for 'hard evidence' of outcomes (usually interpreted as quantitative measures of performance) it may be of value to ensure that efforts are made to capture change at the level of the school in terms of policies and practice. Health and educational outcomes are often reached indirectly rather than directly and revealing the role of the individual school setting – in terms of culture, ethos and structures such as a school council – in mediating outcomes is likely to be important in understanding the processes by which schools improve. Furthermore, this suggests that schools have an important role in helping children and young people overcome some of the negative dimensions of living in disadvantaged circumstances.

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# Appendix 1

## Cheshire Healthy Schools Process Model

## School Process Model

| Stage | | Evidenced by … |
|---|---|---|
| **1A** | Register interest | Initial Meeting Report |
| **1B** | Establish Healthy School Team | Healthy School Team form |
| **1C** | Conduct Audit | Audit Document |
| **1D** | Agree Priorities and Targets | Priority and Target Statement |
| **1E** | Agree Plan | Healthy School Planner |
| **1F** | Review Outcomes | Project Review and Reflection |
| **1G** | Celebrate Achievement | Record of Achievement, Press and Showcase |

# Appendix 2

# Participant information sheets

# Information for head teachers and teachers

You have/Your head teacher has agreed for your school to participate in a research project about the healthy schools initiative and school improvement. As part of this project you are being invited to take part in a semi-structured interview with a researcher to explore your views and ideas about the healthy schools scheme. Before you decide if you want to take part it is important for you to understand why the research is being done and what you will have to do. Please take time to read this information and discuss it with other people if you wish. Please ask me if there is anything that is not clear or if you would like more information about the research.

Thank you for reading this.

**What is the purpose of the research?**
As you will probably know, the healthy schools initiative is part of a government initiative concerned with helping schools become healthy schools so that children develop into healthy young people who achieve their potential. The National Healthy School Standard (NHSS) is the main vehicle through which this work is being carried out. Recently, there has been some interest in examining the relationship between the impact of becoming a healthy school under the NHSS and school improvement. It is the purpose of this research project to explore, through a number of case studies, the extent to which the NHSS is a vehicle for a school's improvement.

**Why have I been chosen?**
Your school has been chosen because it has received national accreditation from the Health Development Agency. Five other schools in Cheshire are also being asked to participate. Two primary schools in each locality of Cheshire - West, Central and East – have been chosen. You have been asked to participate because you know about the healthy schools initiative in your school and have been involved in various activities and developments. The researcher is interested in listening to the views of those who have such experience of the scheme in their school.

**Do I have to take part?**
It is up to you whether or not to take part. If you decide to take part you are still free to change your mind at any time without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect your access to help from the healthy schools support team or access to any resources.

**What will happen to me if I take part?**
If you decide to take part, you will be asked to sign a consent form to show that you agree to take part in a semi-structured interview with the researcher. The interview will take about an hour and will give you the chance to tell the researcher what you think about the healthy schools initiative, what your school is doing and why. You do not have to tell the researcher anything about yourself and you don't have to answer any questions you don't want to. Everything you say will be treated confidentially. If you agree, the researcher will tape the interview so that what you say will be reported accurately. No names of schools or individuals will be used in any report of the findings.

**What are the possible risks and disadvantages of taking part?**
There are no foreseen risks or disadvantages to taking part in this research.

**What are the possible benefits of taking part?**
By taking part you are helping the development of this type of initiative, which may benefit others in the future.

**What will happen to the results of the research study?**
The findings from the interviews will be combined with the other work undertaken in your school, such as observation and focus groups with children, and be written into a report, together with information from the other five schools participating in the research project. This report will be circulated to the Local Education Authority (LEA) which has commissioned this research and possibly more widely. Schools and individuals who take part will NOT be identified in any written report. However, the LEA, as commissioners of the report, will know which schools have participated in the study but NOT which individuals. All tapes will be wiped at the end of the study.

**Who is organising and funding the research?**
The idea and funding for the study has come from the LEA. The Centre for Public Health Research at University College Chester will organise and carry out the research and write the final report.

**Who can I contact for further information?**
If you would like any more details about the research, please contact Miranda Thurston at the Centre for Public Health Research at University College Chester. This can be done by telephoning Miranda (01244 220367) or emailing her on m.thurston@chester.ac.uk.

**Thank you for your interest and co-operation in this research.**

# Information for children

Your school has agreed to take part in a research project about the healthy schools project and how this can make your school a better place to learn. As part of this project you are being asked to take part in a group discussion with a researcher who will ask you about the healthy schools project and what you think about it. The researcher may also want to observe a number of school activities such as what happens during the school council or what do children do during playtime. Before you decide if you want to take part it is important for you to understand why the research is being done and what you will have to do. Please take time to read this sheet and talk about it with your friends and teachers if you wish. Please ask me if there is anything that is not clear or if you would like to know more about the research.

Thank you for reading this.

**What is the purpose of the research?**
The healthy schools project is about helping schools become healthy schools so that children develop into healthy young people who are happy and do well at school. This research project wants to know your views about your school and some of the activities it has developed as part of its healthy schools work that you have taken part in.

**Why have I been chosen?**
Your school has been chosen because it has been awarded the healthy school certificate. Five other schools in Cheshire are also being asked to take part. You have been asked to take part because you know about the healthy schools work in your school and have taken part in a number of activities. The researcher is wants to listen to what you have to say about this.

**Do I have to take part?**
It is up to you if you take part. If you decide to take part you are still free to change your mind at any time without saying why. A decision not to take part at any time will not affect you in any way.

**What will happen to me if I take part?**
If you decide to take part, you and a group of friends will meet with a researcher for about half an hour. This will give you a chance to tell the researcher what you think about the healthy schools scheme, what your school is doing and why. You do not have to tell the researcher anything about yourself and you don't have to answer any questions you don't want to. Everything you and other children in the group say will stay within the group and not be repeated to teachers. If you agree, the researcher will tape the group discussion so that what you say will be reported accurately. No names of schools or children will be used in any written report of the work. The researcher may also want to observe a number of school activities such as what happens during the school council or what children do during playtime and speak to children as they take part in these activities.

**What are the possible dangers of taking part?**
There are no dangers to taking part in this research.

**What are the possible benefits of taking part?**
By taking part you are helping us understand what is going on in schools that might make a difference to how happy and healthy children are, which may help others in the future.

**What will happen to the results of the research study?**
What children tell the researcher will be put together with the other work taking place in your school, such as observation and talking with teachers, and be written into a report, together with information from the other five schools taking part in the research project. This report will be sent to the Local Education Authority (LEA) which is paying for the researcher and wanted this research to take place. Schools, children and teachers who take part will NOT be named in any written report. However, the LEA will know which schools have taken part in the study but NOT which children or teachers. All tapes will be wiped at the end of the study.

**Who is organising and paying for the research?**
The idea and money for the research has come from Cheshire LEA. The Centre for Public Health Research at University College Chester will carry out the research and write the final report.

**Who can I contact for further information?**
If you would like any more details about the research, please contact Miranda Thurston at the Centre for Public Health Research at University College Chester. This can be done by telephoning Miranda (01244 220367) or emailing her on m.thurston@chester.ac.uk.

# Appendix 3

# Consent forms

**Centre for Public Health Research**
**University College Chester**

# CONSENT FORM FOR HEAD TEACHERS AND TEACHERS

## Title of Project: The National Healthy School Standard: a vehicle for school improvement?

Name of Researcher: Miranda Thurston, Centre for Public Health Research

**Please initial box**

1. I confirm that I have read and understand the information sheet dated ……. for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without support from the healthy schools support team being affected. ☐

3. I agree to take part in the above study. ☐

| _____ | _____ | _____ |
|---|---|---|
| Name of Participant | Date | Signature |
| _____ | _____ | _____ |
| Name of Person taking consent (if different from researcher) | Date | Signature |
| _____ | _____ | _____ |
| Researcher | Date | Signature |

1 for participant; 1 for researcher.

**Centre for Public Health Research**
**University College Chester**

# CONSENT FORM FOR CHILDREN

## Title of Project: The National Healthy School Standard: a vehicle for school improvement?

Name of Researcher: Miranda Thurston, Centre for Public Health Research

**Please tick box**

1. I have read and understand the information sheet dated …… for the above study and have had the chance to ask questions. ☐

2. I understand that I do not have to take part in the research and that I can change my mind at any time that I am free to withdraw at any time, without giving any reason, and without support from the healthy schools support team being affected. ☐

3. I agree to take part in the above study. ☐

| _____ | _____ | _____ |
|---|---|---|
| Name of Participant | Date | Signature |
| _____ | _____ | _____ |
| Name of Person taking consent (if different from researcher) | Date | Signature |
| _____ | _____ | _____ |
| Researcher | Date | Signature |

1 for participant; 1 for researcher.

# Appendix 4

## Interview schedule for teachers

# Interview schedule: teachers

1. How did you come to be involved with the NHSS?
2. Can you explain some of your reasons for involvement?
3. Can you explain to me how you got going?
4. Can you tell me some of the things you actually did?
5. Can you explain how the NHSS sits with other school initiatives?
6. What did you hope to achieve through the school's involvement?
7. What do you think has been the impact of the school's involvement?
8. Would these things have happened anyway?
9. Can you say what is it particularly about the scheme that has enabled these things?
10. Have there been any knock on effects to the classroom and teaching and learning?
11. Do you think the NHSS has made any contribution to school improvement (however they define it)?
12. Do you know what other teachers in the school think about the NHSS?
13. Anthing else they would like to say about the scheme and how it has helped the school?

# Appendix 5

## Focus group schedule for the school council and meetings with buddies

# Focus group schedule

## School council

1. Could somebody tell me about school council meetings?
    a. Meetings: number, frequency, timing, who attends.
    b. How are meetings organised: chair, secretary, treasurer, minutes?
    c. What do you do before the meeting? Get other pupils' views?
    d. How is the agenda put together?
    e. What happens during the meeting? What does the teacher do? What do you do? What do other children do?
    f. What happens after a meeting? Feeding back to classmates and class teacher?

2. Can you tell me some of the specific things that the school council has done?
    a. What kinds of things does it talk about?
    b. What kinds of things does it do?
    c. Specific examples?

3. Can you tell me how you get involved with the school council?
    a. Volunteer/apply/chosen?
    b. How long have you been on the school council?
    c. How long can you be on the school council?/Can you decide to stop being on the school council?
    d. Do you have any training? If yes, what training have you had? What/has it helped you with in terms of your role?

4. What difference do you think the school council makes?
    a. To the school.
    b. To your class and other pupils.
    c. To you.
    d. Examples?

5. Can you tell me why you wanted to become a buddy?
    a. What's good about being on the school council?
    b. Is there anything that's not so good about being on the school council?

# Buddies

1. Can you tell me what a buddy does?
    e. Can you give me some examples of the types of things you have done recently? (Explore doing things with other people, including helping people, as well as going to meetings, moving play equipment.)

2. Can you tell me how you get to be a buddy?
    a. Volunteered/applied/chosen?
    b. How long have you been one?
    c. How long can you be a buddy for?/Can you decide to stop being a buddy?
    d. Do buddies have any training? If yes, what training have you had? What/has it helped you with in terms of your buddying role?

3. Can you tell me why you wanted to become a buddy?
    a. What's good about being a buddy?
    b. Is there anything that's not so good about being a buddy?

4. What difference do you think buddies make?
    a. To the school.
    b. To your class.
    c. To you.
    d. Examples?

5. Does anyone in school help you with your buddy role?
    a. Teacher.
    b. Healthy school co-ordinator.
    c. Midday assistants.
    d. What do you do if there are things to sort out, for example, with other children being naughty?

# Appendix 6

## Observation schedule for school council

# Observation schedule: school council

1. How children are welcomed and organised.
   a. What is provided for them: drinks, biscuits, paper, pens.
   b. Are children familiar with the routine and organised themselves efficiently?
   c. Dynamics between the teacher and the children.

2. How the meeting gets started.
   a. Who is chair, secretary, treasurer?
   b. Agenda?
   c. Minutes?

3. How the business of the meeting is organised.
   a. Teacher-led – child-led?
   b. Information giving/sharing?
   c. Children participate in decision making?
   d. Opportunities to explain decisions?
   e. Opportunities for children to raise issues?
   f. Dynamics between the teacher and the children

4. How the meeting is closed.

5. What issues are on the agenda?
   a. Comparison with previous agendas and minutes – follow through of issues?

6. What are the dynamics between the teacher and the children?
   a. Confidence of children to express a view?
   b. Do children know and observe protocol for meetings?
   c. Do children raise issues from their classes?

## Appendix 7

## Observation schedule for playtime and lunchtime

# Observation schedule for playtime and lunchtimes

1. What types of activities are there in the playground?
    a. Physical activities.
    b. Games.
    c. Quiet area to sit, talk or read.

2. What types of interactions are there?
    a. Child-child.
    b. Older child-young child.
    c. Child-adult.

3. What do the buddies do in the playground?
    a. Passive/active/proactive.
    b. Join in with activities/pastimes.
    c. Report people.
    d. Involve adults.

4. Were there any incidents?
    a. What kind of incidents?
    b. What happened?
    c. How resolved?